# THE AMERICAN PRACTITIONER.

MARCH, 1876.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

## Original Communications.

### CEPHALIC VERSION.*

BY M. B. WRIGHT, M. D.

Obstetrical experience established the fact long since that presentations of the head were the starting points of a natural and easy labor; and that shoulder presentations were types of labor requiring interference. The exceptions to this

* Prof. Wright has sent this most valuable paper, with the following note to one of the editors of the American Practitioner:

PROF. PARVIN—*Dear Sir:* Your request has come to me in such words of kindness, I do not feel like saying No; and yet an affirmative response must be coupled with the condition that I may be permitted to write in a free, every-day style. I endeavor to garner current facts, but I have no room for the newly-coined phrases with which the profession is so heavily burdened. Indeed I begin to fear that our profession will be, ere long, concealed under the rubbish of an unknown tongue. Even now the thoughts of the later generation are conveyed to the fathers in a sort of pantomime.

You ask me for an expression of my views on Cephalic Version. They are now, as in the past, favorable to it under certain conditions. I have spoken on this subject so often and so much, that I can scarcely get my energies up to say more. You reminded me that on all practical subjects we needed "line upon line and precept upon precept," and with this consideration I am encouraged to proceed.

proposition are to be found in those cases of spontaneous evolution or expulsion, which, in this place, will scarcely admit of consideration. It is obvious, therefore, that when a wrong presentation can be converted into a right one, it should be done. Now comes the practical question, which extremity of the fetus shall be made to take the place of the shoulder?—and in framing the answer, several considerations must be brought in review.

Labor, complicated by exhausting hemorrhage, requires speedy delivery. If the expulsive efforts of the uterus are too weak for safe reliance, the feet must be sought and traction made upon them. The great motive to action here, is less the safety of the child than that of the mother, although the former may be saved by timely establishment of the independent circulation, in other words delivery.

Rupture of the uterus, in all cases brought under my observation, occurred while the presenting part of the fetus was above the brim of the pelvis. Delivery in these cases must, of necessity, be artificial. The rupture and the loss of contractile power follow each other instantly as cause and effect. The fetus dies from the same shock—recedes from the superior strait beyond ordinary vaginal touch. Any attempt to replace the head preparatory to the use of forceps would be futile. Delivery by the feet is the only sensible suggestion.

In *general exhaustion*, with feeble uterine action, danger being imminent, podalic version would seem to offer the most certain ground of safety.

When convulsions are associated with a shoulder presentation, the question is not as to the speed of delivery by podalic or cephalic version; but which method of turning is more calculated to increase inordinate action? This question will be answered before the close of our paper. It may be said just here, however, that we must keep in view the fact that whether the uterus be the original seat of abnormal action or not, all means of local irritation are to be avoided. It is the observation of those familiar with the origin and progress of

eclampsia, that the bare introduction of the hand into the cavity of the uterus has provoked general spasms and increased those already existing. The doctrine of albuminuria may be used as a pastime toy, but the susceptibility of the uterus, its sympathetic relations, and ready transfer of abnormal actions, remain the same. In no particular does it aid us in the treatment of the formidable disease while labor is in progress.

There is danger in shoulder presentations to the child; indeed, so great is this danger that more than one-half the children are born dead. Possibly the life of the child may have been destroyed by some unknown cause, and the wrong presentation followed as a consequence. A lifeless, small sized fetus, surrounded by a considerable quantity of liquor amnii, gravitates more or less with the changes in the position of the mother, and is moved from point to point by uterine contraction. Such at least has been my observation. In other cases the living child takes the unnatural position, and dies before being released. In either condition, the mode of delivery is to be determined by the demands of the mother rather than of her offspring.

Cephalic version is performed with a view to save the life of the fetus. It is admitted on all hands, that a timely change of presentation from the shoulder to the head places the child in a position almost as favorable as if the vertex had originally presented.

Another important fact is worthy of mention. Cases have occurred within my own experience, in which the shoulder was so wedged in the superior strait as to render the passage of the hand through it, in search of the feet, impossible. Under these circumstances, mutilation or substitution of the head in place of the shoulder, are the methods to secure delivery left. It may seem strange to many that cephalic version has been performed with comparative ease, after several ineffectual efforts had been made to turn by the feet. Nevertheless such is the fact.

Cephalic version is an expression of every day usage, yet

its interpretation is far from being definite; indeed, it is a misnomer. The object to be achieved is simply to bring the head from its lodgment in the iliac fossa down into the brim of the pelvis. This, and nothing more. Surely such a movement should not be called turning.

The authorities differ in regard to the instructions given for the accomplishment of the above object. A very indefinite lesson consists in "raising the shoulder and pushing it out of the way." If we attempt this, the head and breech being somewhat fixed points, we shall merely reverse the bow. Push aside? How? With the shoulder raised, will not the breech impinge against the uterus on the one hand, and the head on the other, thus defeating the very object we have in view?

The method of changing the presentation through the walls of the abdomen has its enthusiastic advocates. Even breech cases were, at one time, considered so far unnatural as to require interference, and the directions of a double force were doubtless the important points to be kept in view. One hand over the breech pushing upwards, and the other over the head pushing downwards, under given conditions accomplish much. Without claiming to have had much experience on this subject, it has seemed to me that the essentials to success consist of a small sized fetus, a good amount of surrounding liquid, and the abdominal walls not much thickened by fat. These remarks are applied more particularly to presentations of the shoulder. Those who are most conversant with this method of turning, fix upon some period after the sixth month of gestation, and before the fetus has filled the uterus, as the time when this is most easy of performance. Establish this as a rule, and it will be seen that we must be constantly examining our patients during pregnancy, for the fetus very often engages in playful evolutions. Not only this, but if there is a tendency to any particular presentation, it will soon readjust itself, no matter how often we may effect the change. If the change can be effected while labor is going on, it may remain under pressure from uterine con-

traction. It must be recollected that the uterus is a sensitive organ, and may be excited to premature contraction by pressure without and the forced movements of the fetus within.

Dr. Braxton Hicks, whose opinions are occasionally quoted as authority by our countrymen, has published what he has been pleased to call "combined external and internal version." In shoulder presentations, his plan is thus described: "Introduce the left hand into the vagina, as in podalic version; place the right hand on the outside of the abdomen, in order to make out the position of the fetus, and the direction of the head and feet. Should the shoulder, for instance, present, then push it with one or two fingers on the top in the direction of the feet. At the same time pressure by the outer hand should be exerted on the cephalic end of the child. This will bring down the head close to the os; then let the head be received on the tips of the inside fingers. The head will play like a ball between the two hands; it will be under their command, and can be placed at almost any part at will. Let the head then be placed over the os, taking care to rectify any tendency to face presentation."

The author of the above quotation claims to have been the first to recommend "combined external and internal version." As late an author as Meadows accords to him originality, in having "first performed and fully described the operation." In this declaration we have another evidence of the true emphasis often given the interrogatory, "Who (what Englishman) reads an American book?" As Dr. Hicks estimates his procedure above all price, and greatly in advance of all others, it becomes our duty to devote to it a small share of attention. The first point to be noted is his management of the shoulder.

When the membranes are entire, the fetus afloat as it were, and folded on itself, mere pressure on the shoulder may be sufficient to change the presentation, and especially when assisted by outer pressure on the head. But after the liquor amnii shall have escaped, and the shoulder has become fairly engaged in the upper strait, pressure upon the shoulder does

not overcome the material obstacle to the movement of the fetus, viz., the close contact of the breech to the wall of the uterus. The force exerted upon the head is transmitted to the presenting shoulder, and it sinks lower into the brim of the pelvis, and will there remain until the breech is dislodged.

The next movement is to so place the fingers that the head will fall upon their tips. What advantage is to be gained by this it is difficult for the imagination to conceive. Perhaps it is suggested upon the principle that it were better to have "something for idle hands to do."

"*The head will play like a ball between the two hands.*" Is not the body attached to the head, and can you refuse it successfully a part in the interesting ball game? Compare the facts in the case with the creations of fancy, and see which have preponderance.

When we engage in the great duty of saving life, and perhaps lives, we must look sternly at what is before us. To remove a shoulder, wedged in the brim of the pelvis, the membranes having been ruptured, and the uterus now contracting on the fetus, is no easy task. To change the presentation to a more favorable one, requires action of both head and hands. The tips of the fingers will furnish but little aid where muscle and skill are put to so severe a trial.

Some time during the year 1847, I was called to see a patient in labor, to aid more particularly in determining the nature of the presentation. Two physicians were in attendance. The one diagnosed a shoulder, the other a breech. To my first touch there was evidence of a shoulder, and in a movement under uterine contraction it was moved out of the way, and the breech took its place. After my attention had been directed for some minutes to the movements of the seven months' fetus from side to side, it was decided that I should turn by the feet. At this time the shoulder presented, and while my hand was passing it to seize the feet, I observed an inclination in the head to fall into the brim of the pelvis. I pushed the shoulder aside, and the head became fixed as a

natural presentation. The uterus was now acting with force, and the labor soon terminated.

The movements of an immature fetus, brought under control of the lower contractile fibres of the uterus, were not new to me, nor did the adjustment of the head induce any immediate reflection. Some time subsequently, however, a case of shoulder presentation occurred in my own practice, which brought to my recollection the preceding case. The child was alive, the first stage of labor not completed, and the question came to my mind in full force, is it possible to bring down the head? The answer came promptly, I will try. Success attended my efforts; I scarcely know how. After this, the method to be described was devised.

Three successful cases occurred in 1850, which were reported in the Western Lancet, 1851, by the physicians in attendance.

In 1854, many years before we had the pleasure of hearing from Dr. Hicks on the subject of "combined external and internal version," we wrote an essay on "*Difficult Labors and their Treatment*," embracing the above mentioned cases. The plan of action there described is as follows:

I have in my mind's eye a woman in labor, and my diagnosis is a right shoulder presentation—the head lying in the left, and the breech in the right iliac fossa. To secure delivery, the head, breech or feet, must be made to take its place. I prefer the former, and will endeavor to effect the change. The right hand is now in the cavity of the pelvis, and has control of the shoulder. The left hand placed on the abdomen, over the breech of the fetus, makes firm pressure with a view to force the breech with the inferior extremities towards the middle of the uterine cavity. This occasions a movement of the body, and a slight elevation of the shoulder. Now the latter is being pushed towards the breech, which, with the body, moves in a curvilinear direction towards the fundus of the uterus. As the shoulders move, the head follows, until finally it occupies the superior strait, without any direct action upon it. Possibly the hand which has been act-

ing upon the shoulder may be required to place the head in proper position.

When the left shoulder presents, the back looking in front, as in the former case, the extremities are reversed in position. In changing this presentation for the head, the left hand should be employed internally to act upon the shoulder, while the right manages the breech. All this is to be done in the absence of pain, but the control of the head should not be relinquished, nor of the breech, until contraction of the uterus fixes it in place.

It will be observed that the palmar surface of the fingers is in contact with the shoulder, and can apply more force, and give more efficient direction to that force, than when the back of the fingers is used, as in the manipulations of Dr. Braxton Hicks. Again, it will be perceived that lateral force upon the breech can be increased to a much greater extent than downward force upon the head. Not only this, the breech has an empty space, more or less, in which to move, while the head encounters a degree of resistance in its entire descent.

When the arm escapes from the brim of the pelvis, and is found full length in the vagina, it interferes but little in the performance of podalic version, but in cephalic, it must be restored as near as possible to its original position before any attempts are made to remove the shoulder. The accomplishment of this object is not always an easy task. As the presence of the arm is very much dreaded by many, I will be excused for describing a method which I have found more successful than any other. The hand must be flexed on the fore-arm, and this in turn on the arm. Before, or while an attempt is being made to elevate the entire extremity above the body of the fetus, the shoulder must be, to some extent, pushed up, by pressure over the breech and direct force with the hand in the vagina. This changes the relative length of the arm, and facilitates the movements of the part lying below the brim.

It has been stated that cephalic version is designed to save

the child whose life is in extreme peril. But it may secure important service outside of this, even the saving the child from mutilation. A few quotations from our own authors may not be amiss in this connection.

Dewees has left on record many cautions to young men, which it might be well for themselves and patients if they would more frequently heed. He advises them, in cases of difficulty, to call a "skilled operator" to their aid. Then he says, "If the case has been mismanaged, before a judicious practitioner has been consulted, he may not, perhaps, be able to terminate the labor by turning with any prospect of success to the child; he is then to consult the interest of the mother alone, and this, perhaps, will be best advanced by waiting so long as the child may continue to live." This procedure is advised on the ground that when turning by the feet is impracticable, cutting instruments must be used, but not until the death of the child has been made certain.

From "James's Midwifery" is extracted the following: "When turning has not been practicable, if the child was supposed to be alive, the os uteri has been cut, or the Cæsarian section, has been proposed and practiced. If dead, it has been extracted by pulling down the breech with a crotchet; and sometimes, in order to assist delivery, the body has been mutilated, or the head opened with the perforator."

When upon the treatment of shoulder presentations by turning, Prof. Meigs says, "As to the difficulties of it, they are so great, in a womb long drained of its waters and lashed into fury by a long period of unavailing irritation suffered previously to the operation, that nothing but practical experience of them can make them known, unless, indeed, the fact be understood that it can not in some instances be effected at all, and that we are obliged to extract the child double, after having the thoracic viscera removed, as well as those of the abdomen, by the crotchet and perforator; upon doing which the fœtal remains may be drawn forth."

By reference to the chapter on the treatment of shoulder presentations, in "Miller's Human Parturition," may be read

the following: "It has been already declared that cases will now and then be met with in practice, in which, on account of the excessively contracted condition of the uterus, it will be found wholly impossible to deliver by turning. I have had three or four cases of this kind. And what is to be done for the relief of the woman, under such circumstances, will now claim our attention. I say for the relief of the *woman*, because the *child*, being dead as it always is, when the mother is brought into such fearful peril, has no claims to our regard; and even though it were alive, the paramount claims of the mother forbid the doing of anything which might increase the hazard of her life. It is manifest that all attempts to *forcibly* pass the hand between a powerfully contracted uterus and the fœtus, must be extremely painful, and may cause fatal rupture to the organ; no such attempts can, therefore, ever be justifiable. The only resort is mutilation of the child, either by eviscerating its trunk, to enable the operator to extract it doubled upon itself, in imitation of the natural process of duplication, or by decapitating it, in order that the body and head may be separately extracted."

Dr. Bedford concludes his chapter on shoulder presentations with the following paragraph: "It may, however, happen that you will not be called to a case until it is too late to attempt the version of the child, and that under these circumstances, from the length of time which has elapsed, the shoulder is so far forced into the pelvis, as to render the effort to bring down the feet utterly impracticable. What, in such a contingency, is to be done? Here you will be compelled to have recourse to evisceration, or to the decapitation of the child."

Dr. Byford, in his work on the "Theory and Practice of Obstetrics," says, "In shoulder presentations, when we can assure ourselves that the fœtus is dead, we ought not to think of any other operation (embryotomy), as it is far less hazardous to the woman than turning."

All this is more than sufficient to establish the fact that in shoulder, as well as in other presentations, podalic version

can not be safely performed, if at all. But it does not prove that evisceration is now a necessity. To state the affirmative is to sustain a grave and fatal error. I have performed cephalic version after having made repeated and long continued, but ineffectual, efforts to turn by the feet.

In a case reported by Dr. Terry, in the March number of the Western Lancet, 1851, we have satisfactory confirmation of the above statement. When called to Dr. Terry's assistance, I found the arm, which originally presented, together with the funis and right leg, the latter having been brought down by the doctor in his efforts to turn. Taking advantage of this, I endeavored to turn also, but failed. The leg and shoulder were then in turn placed above the brim, and the head brought in position. The head was too large to pass the brim, consequently the perforator was used, followed by the forceps, and delivery completed.

I may here be allowed to state that our friend Byford was never more mistaken than when he declares evisceration to be a safer operation than cephalic version. It is self-evident, aside from experience, that version, whether podalic or cephalic, can be performed more easily immediately following the rupture of the membranes, than after the uterus has become firmly contracted on its contents. If driven to the necessity of performing one or the other in a shoulder presentation, the uterus having taken strong grasp of the fetus, I should, without hesitation, choose the latter. It is greatly the safer method. A forcible effort to turn by the feet has produced contusion, inflammation and rupture of the uterus. The bare introduction of the hand into the cavity of the uterus, with a view to turn, has increased the frequency and force of puerperal convulsions. Some years ago I saw a case, in consultation, of tedious, inefficient labor, and the general condition of the patient was such as to call for more speedy delivery. The medical attendant introduced his hand into the uterus, preparatory to turning, when suddenly there came a convulsive seizure, at the end of which the patient ceased to breathe.

In cephalic version, conducted according to our method for converting a shoulder into a vertex presentation, the hand does not enter the uterus—does not come in contact with it. This point has been warmly criticised, nay flatly contradicted. Dr. Miller, in his "System of Obstetrics," says: "It is understood, of course, that in this manipulation the hand is operating in the uterine cavity, notwithstanding the assertion of Dr. Wright, made, as I suppose, without due deliberation, that 'the hand does not enter the cavity of the uterus, and consequently neither its walls, nor any portion of them, are forcibly pushed out.'"

If Dr. Miller had considered the question *with* "due deliberation," he would have expressed an opposite opinion. Let the reader remember that the shoulder is in or below the brim of the pelvis, outside the uterus, and it will be apparent that when the hand is acting it is below the shoulder. To pass the hand through the brim, beyond the shoulder into the cavity of the uterus, would be to defeat the object. Dr. Miller evidently did not have a just comprehension of the essential points in cephalic version respecting the treatment of shoulder presentations. Nor does Prof. Byford, if we may judge from our reading of the last edition of his obstetrical work. He says the method I have practiced is "about the same as recommended by other authors." I regret that the doctor has not named the authors, for, notwithstanding my extensive examination of obstetrical works, I have not found a single mention of the process, except to give me credit for having first suggested it to the profession.

To close this part of my paper, I may be permitted to quote the language of Hodge: "Dr. M. B. Wright, of Cincinnati, in a valuable paper published in 1850, recommends another mode of operating, which is certainly very simple, safe to the mother and child, and, according to Dr. Wright, very successful. It is certainly a very ingenious and scientific suggestion, very creditable to the author, and deserving the serious attention of every accoucheur. In its performance little or no pain would be inflicted upon the patient;

there would be no risk of contusion, laceration, or irritation of the vagina or uterus, and no possible injury to the child. On the contrary, it would afford the infant the best chance of escaping in safety from its perilous position, and not enhance the danger to the patient."

Except in a few instances, I have placed the patient on the back, in performing cephalic as well as podalic version. In cases of great difficulty, I have succeeded with the patient in the knee and elbow position. The advantages to be derived from this position are so great, it seems surprising that it is not more frequently selected. Gravitation partially clears the upper strait of the presentation, the hand passes in a more direct line into the uterine cavity, and meets with less obstruction in its ascent.

By reference to Miller's "System of Obstetrics," it will be seen that he honors my "prize essay" with criticisms covering seventeen pages. The first sentence of the closing paragraph reads thus: "To me it seems that cephalic version, under the circumstances we are now considering, is an *unfinished* operation." So it is; so is the correction of deviated presentations of the vertex; so is the adjustment of the face from the conjugate to the oblique diameter, or the aid we may give the chin in its efforts to rotate forwards; so is the removal of the umbilical cord, in cases of prolapsus, to that symphysis in which it is least liable to pressure, or its equally difficult and safe return to the uterine cavity; or the separation of the placenta when attached over the mouth of the uterus. Surely no one would object to manipulation in these cases on the ground that it was an "*unfinished* operation," that it alone did not complete delivery.

As formerly intimated, cephalic version is designed to accomplish two objects; first, to place the fetus in a position favorable for natural delivery; and second, to make artificial delivery practicable and safe.

When the head is made to take the place of the shoulder, at an early period of labor, the chances of a natural labor are as if no malpresentation had existed. At a later period,

the practitioner must decide upon his own method of delivery, and he must be governed by the nature of his case and the attendant conditions. At a still later period he may have failed in his efforts to turn by the feet, and afterwards succeed in the delivery by cephalic version and the use of the forceps.

The following case presents some interesting points, and I place it as an appendix to my paper:

Catherine Daiker, aged 40, entered the Cincinnati Hospital, January, 1876. She has had ten children. All her labors were natural, except the ninth, which required the use of instruments. A short time after having resumed her usual avocations, she observed a swelling at the vulva, which resulted, two years ago, in procidentia of both bladder and uterus. They could be returned into the cavity of the pelvis with moderate pressure, and as readily escaped on exercise. When the patient entered the hospital, she was about eight months pregnant. The bladder appeared externally from straining or exercise, and also the *neck* of the uterus. The latter bore none of the evidences of pregnancy. It was greatly elongated, its walls were thin, and its whole cavity, from the external to the internal os, expanded.

February 10. The membranes ruptured without pain. On examination, I found the os one-third dilated, with the feet and one hand resting at the brim of the pelvis. The patient was kept on her back, and carefully watched.

Last evening, February 13. The pains of the first stage of labor commenced, and my presence was requested. I now found an arm and a leg in the cavity of the pelvis, the left shoulder within easy reach. The practical question presenting itself was, shall I deliver by the feet or head? The latter could be seized and delivery accomplished without difficulty, but I entertained the fear that in the descent of the head, after the escape of the body, the bladder might be dragged down and injured, while its descent could be more certainly prevented with the head in advance. I therefore decided in

favor of "cephalic version by the bi-manual method." The leg was replaced, then the arm, above the brim of the pelvis; pressure was made over the breech, and against the lower shoulder, when the head became properly adjusted at the superior strait. Expulsive efforts were slow and feeble, but, with slight instrumental assistance, labor terminated without unusual delay.

The change of presentation was effected in presence of the ward nurses and several of the hospital *intérnes*. The latter, previous to my arrival, had correctly diagnosed the presentation, and with much interest watched the progress of the case to its close.

The condition of the neck had undergone little or no change, until the tissues began their preparation for delivery, when it became speedily obliterated or lost in the body.

Perhaps I ought to be a little more explicit in giving the presentations and method of turning.

The right arm and leg were in the vagina, the head in the right iliac fossa, the back resting on the spine of the mother, above the promontory of the sacrum. With my right hand in the cavity of the pelvis, I replaced the leg and arm above the brim; at the same time acting upon the head with my left hand, by external pressure. Manipulating thus the body of the fetus was reversed, the back looking in front and the left shoulder presenting. My right hand was now withdrawn from the pelvis and the left substituted. Lateral pressure was made upon the shoulder and upward pressure against the breech, and the effect was as above described.

CINCINNATI.

# PALATO-PLASTY.*

BY DAVID PRINCE, M. D.

I. RECOMMENDING *the employment of the galvano-cautery to diminish the loss of blood, and to secure facility of performance and certainty of result.*

II. SUGGESTING *the introduction of automatic needles, both for the introduction of the platinum wire for the cautery, and for the taking of the final stitches for the closure of the fissure.*

III. OFFERING *a new interpretation of the functions of the muscles in the pillars of the fauces.*

IV. REVIEWING *the surgery of the hard palate, with suggestion.*

PART I.—STAPHYLORAPHY. The operation for closing the cleft soft palate, though studied and improved since its introduction by Gräfe in 1816, has not yet been brought to perfection.

The congenital cleft is not usually attended by any other loss of substance than that which is consequent upon defective development, as in the case of cleft of the upper lip, in which, though the fissure may be wide, the parts readily yield to the traction necessary to bring the lateral parts to meet in the median line.

In the case of the lip, the detachment of the elastic tissues of the face from the bone renders this approximation easy. In the cleft palate the difficulty to be overcome is the tendency of the two halves of the palate to fall asunder. To remedy this difficulty, various divisions of muscles have been

*A portion of the matter of this paper, original with the writer, has appeared in the St. Louis Medical and Surgical Journal for January, 1875, and has been copied into the London Medical Record, and into the Half Yearly Compendium, and is distinguished by single quotation marks, while the rest of the original matter appears here for the first time.

practiced. Dieffenbach, thirty years ago, made an incision on each side, at the distance of a line from the cleft and parallel with it. In this incision the transverse fibres were divided and the suture line was relieved in part of the muscular traction upon it. The fear of hemorrhage prevented the making of the incision at a greater distance from the margin of the cleft. It is obvious that an incision so near the suture line endangers the circulation, and the consequent vitality of the tissues.

To Sir William Fergusson is attributed the expedient of the division of the levator palati, the tensor palati, and the palato-pharyngeus. The division of the palato-glossus has been added to the list.

The division of the palato-pharyngeus and of the palato-glossus by Fergusson, was adopted on the supposition that these muscles tend to pull the two halves of the palate away from each other, but this supposition is believed to be erroneous. It is found by observation of the movements of the curtain of the palate in halves, that the contraction of both these pairs of muscles approximates the opposite sides of the cleft, causing the two halves of the uvula, in most cases, to come in contact.*

'The mode of this will readily be understood by recalling the manner in which the tongue is protruded by the genio-hyo-glossus. So, while the palate is stiffened by the fibres of the tensor palati, the levator palati, the azygos uvulæ, and by a few fibres of the palato-glossus and palato-pharyngeus, the main portions of these last two muscles engage in approximating the two halves. To cut these muscles is, therefore, physiologically absurd, besides endangering their future functional perfection. Without the action of the palato-pharyngeus, the perfect articulation of the gutturals is impossible. The loss of the function of the palato-glossus would not be seriously felt in articulation.

* See Gray's Anatomy, American edition of 1870, p. 344.

If this reasoning is founded on correct observation, the division of these muscles must speedily go into disuse. Their division is the result of the fear of the hemorrhage arising from the vertical incisions first made by Dieffenbach. Now that we have a safe way of making these incisions, we may dismiss this fear.'

The muscular fibres of the posterior pillars are chiefly those which approximate the two sides of the palate, at the same time that the palate is drawn backward by the superior constrictor to the posterior wall of the pharynx, by which movements communication is cut off between the lower pharynx and the upper. In this act the two sides of the pharynx are approximated; and if the palate were divided vertically in the center and again united by sutures, these muscular fibres would act with the sutures and not against them.

Again, the muscular fibres of the anterior pillars are those which approximate the two sides of the pillars at the same time that the palate is drawn forward to prevent communication between the mouth and pharynx. If, as before, we suppose the palate to be divided vertically in the center and again brought together by sutures, the action of these muscles would be *with* the sutures and *not against them.*

Again, it is very important to the future completeness of the function of the palate, that these four muscles should have their perfect activity. If the palato-pharyngeus is impaired in its action, the communication between the upper and the lower pharynx can never be closed. The impaired action of the muscular fibres of the anterior pillars is less important in relation to the voice, but the action is essential to some of the functions of the mouth, among which is the use of the blow-pipe. The division of these fibres, either by incision or by the heated wire, is to incur the certainty of the impairment of their power of contraction, and the risk of its complete and permanent destruction.

This view of the physiology of the muscles of the pillars of the fauces, that in contracting they approximate the two

sides of the veil of the palate, was explained in a lecture before the St. Louis Medical Society, in November, 1874; and in the following January the St. Louis Medical and Surgical Journal contained a report of the lecture and of this physiological view. At the meeting of the Society the view was called in question, as one which required further proof before it could be accepted. Dr. John T. Hodgen, an accurate anatomist and a careful surgeon, undertook to find out whether or not it was so. The following extract of a letter gives the result:

"St. Louis, Mo., July 10, 1875.

"Dr. Prince—*Dear Sir:* It is due you to say (after dissecting the pharynx and soft palate, with a view to learn the action of the muscles), that the palato-glossus and palato-pharyngeus do, I am sure, in the act of deglutition, tend to draw the sides of the soft palate toward the median line, and, in case of cleft palate, to approximate the two parts, aided, of course, by the constrictors. I can not now perceive any benefit to be derived from cutting these muscles in operating for cleft palate. * * * * *

Respectfully, John T. Hodgen."

The objection here urged does not apply to the division of those muscular fibres which traverse the veil of the palate transversely. Their action is directly antagonistic to that of the sutures, and hence the tendency is to pull apart the approximated halves of the palate. In this view, there should be a vertical incision on each side, dividing the transverse fibres of the circumflexus or tensor palati; and the more complete this division, the more complete is the suspension of the traction upon the sutures, to remove which is the object of the incision.

This free vertical incision, however, involves the risk of troublesome hemorrhage from the branches of the posterior palatine arteries, which, from their position, can neither be tied nor compressed.

The employment of the galvano-cautery obviates this objection, and encourages the operator to make as free a division of the parts as he may think advantageous, without regard to the vessels. In executing this division, some of the fibres of the levator palati, in their terminal portion, must be divided, together with the terminal portions of some of the fibres of the palato-pharyngeus, and the palato-glossus; but being divided where these fibres are intermixed, no permanent impairment of the action of these muscles can be produced, while all the advantages of temporary inactivity are secured.

There can be no fear of the permanent impairment of these muscular fibres, because the incision can never be complete. It is like making a perforation of a muscle, leaving its border fibres uncut. The central cicatrix, ultimately forming, serves to make continuous the action of the fibres in both directions from the cicatrix.

On the other hand, as hitherto practiced, the division of the pillars of the fauces by the knife or scissors, is made from the exposed or mucous side, and if complete, there is a possibility of the ultimate covering of the cut ends of the fibres by mucous membrane separating the fibres, so that the action of one part of the fibre is permanently disconnected from that of the other. If, therefore, it were thought best to divide these fibres, it would be better to make the incision without the complete division of the mucous membrane, in order not to leave a gaping wound into which the mucous membrane may sink in healing, thus cutting off the muscular connection. This proceeding is practicable, though more difficult than the division of muscle and mucous membrane together, by a cut from the mucous surface into the muscular surface.

Previous to the adoption of Fergusson's method of dividing the muscles of the pillars of the fauces, 'Dieffenbach had made vertical incisions in the soft palate. These incisions do not interfere subsequently with the functional movements of the palate.

(Velpeau by Mott, vol. III, p. 396): "Of the side incisions through the velum, one is made on each side of the cleft, plunging the bistoury in half an inch from it and half an inch distant from either end of the cleft. The bistoury is then carried, with a sawing motion, directly to the hard palate. Considerable blood flows, and the mouth must be washed frequently with cold water."

Dieffenbach recommended that the parallel incisions should be made after the completion of the sutures. The dangerous hemorrhage liable to occur led to the abandonment of this plan. The galvano-cautery permits us to restore this proceeding of Dieffenbach, and to carry it so far to the lateral base of the palate as to make the incision most effectual, without fear of the loss of blood. Furthermore, we are able to make this the *initiative* proceeding in operations upon the soft palate. By this means the automatic movements of the palate are annulled, and the paring of the edges of the fissure is performed with much greater facility. Even under ether, the half uvula on each side rises and falls with respiration, and the half palate approximates and recedes. The movement, in a great degree, ceases after the vertical incision.

The incision made by Dieffenbach had for its object simply the relief of the strain upon the sutures, and was practiced as the last step in the operation. With the cautery wire, and as a first step, this incision greatly facilitates the operation, at the same time that all possible strain upon the stitches is prevented.

Still further, these cautery incisions are packed full of oiled paper, which is held there by the sutures in order not only to take the tension off from the sutures, but really to crowd those surfaces together which are expected to unite. These stuffed openings, one on either side, will close up afterward. The crossing of muscular fibres favors this closure.

On the other hand, the muscular fibres all pull away from the median line, making a tendency to become larger instead of smaller. This pull upon the median line is sufficient, after union, to approximate the separated bony arch of the mouth,

where there is, at the same time, an opening in the hard palate, making the fissure between the mouth and the nose narrower. This is a reason for closing the soft palate first and the hard palate afterward.'

The vertical division of the outer part of the veil of the palate, including the mucous membranes, the greater part of the transverse fibres of the tensor palati, and portions of the fibres of the levator palati, the palato-pharyngeus, and the palato-glossus, is executed in a manner readily comprehended by a glance at Fig. 1.

'Fig. 1. The method of the galvano-cautery application to the soft palate. The field is as if upside down; the soft palate is for convenience conceived as if in a line with the hard palate. *A A*, the fissure through the hard palate and the soft. *b* and *CC*, lines of incision in the hard palate. *E E*, platinum wire in position with the loop on the other side of the membrane to be divided, being thus hidden from view. The dotted line between the portions of the wire indicates the line of cautery incision. *F F*, silver tubes with wood intervening, sliding down on the wires to the surface of the palate, where the incision is to be made. The passage of the current is controlled by an interrupter in a pedal. The strength of the current is regulated by the depth to which the plates of the battery are immersed.'

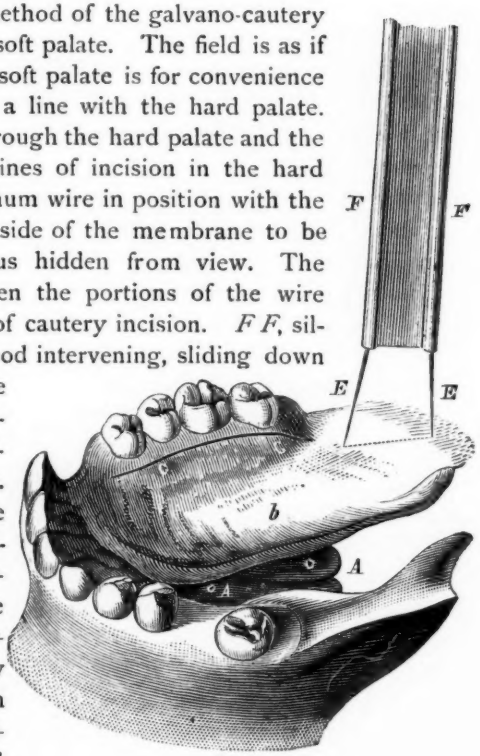


Fig. 1.

A double or looped thread is first secured in the position desired, and by means of this thread a platinum wire is

drawn in so that the loop of wire is behind and the two free ends of it are forward. Each of these free ends is inserted into a silver tube, held in relation with its fellow by the interposition of wood or vulcanite, and by these tubes inclosing each a leg of the wire, connection with the battery is secured. The free ends are moderately drawn until the heated loop of the wire has cut through. The expedient is then practiced upon the other side. The muscular fibres are so far paralyzed by this division, that the edges of the fissure can easily be seized, and their mucous edges pared off. A very convenient forceps for this purpose is that of Dr. Whitehead, and is reproduced in Fig. 2.

Fig. 2. Whitehead's forceps for holding the margin of the palate during the working of the scissors.

For paring the edges of the fissure, great facility is afforded by a set of scissors invented by Mr. A. M. Leslie, instrument maker, of St. Louis, which are represented in Figs. 3, 4, 5, 6, 7, 8 and 9.

Fig. 3. Fig. 4. Fig. 5. Fig. 6. Fig. 7. Fig. 8. Fig. 9.

LESLIE'S NIPPER SCISSORS.

The edge of one blade is made of steel, while the edge of the other blade is surmounted by a groove of soft metal to receive the first blade. It is practicable, by scissors of this construction, to cut in every direction and to follow round a semicircle.

At first the advantage of first making the cautery incision was not appreciated, and in paring the edge of the fissure as the preliminary step, the movements of the two sides of the palate were very perplexing. On adopting the plan of first making the deep incision, one on each side, by the heated wire, this perplexing motion of the parts no longer occurred, and the seizing and paring of the edges became more easy of execution.

In the introduction of the needle for carrying the thread, which is the pilot for the platinum wire, it is important that the operator should be able to appreciate where the point of the needle enters and where it is to come out. It is to be remembered that each lateral half of the soft palate is wedge-shaped, and it is in the thick part of the wedge that this incision is to be made. One mucous surface, with its muscular substratum, glides easily upon the other, and the needle, owing to this gliding, may come out too near the fissure or too distant from it.

FIG. 10. NEEDLE.

*a a.* Shaft, with handle, bent backward to be out of the line of vision.

*b b.* Thread which will in use fall below the hook, and be drawn through the substance perforated by the point of the hook or needle *d*.

*c.* Slide, with a foot-piece, having in it an orifice to receive the needle, and a slit in the orifice to allow a thread to pass through it.

*d.* Hook with an eye near the point.

The thread is picked up by a tenaculum.

To remedy this difficulty, the needle described in Fig. 10 was contrived. The guard over the point makes it easy to be certain of the position of the point of the needle in entrance behind the palate, and the pressure of the guard makes the place of exit equally certain.

Fig. 11. Needle with Black's pick-up (approaching).

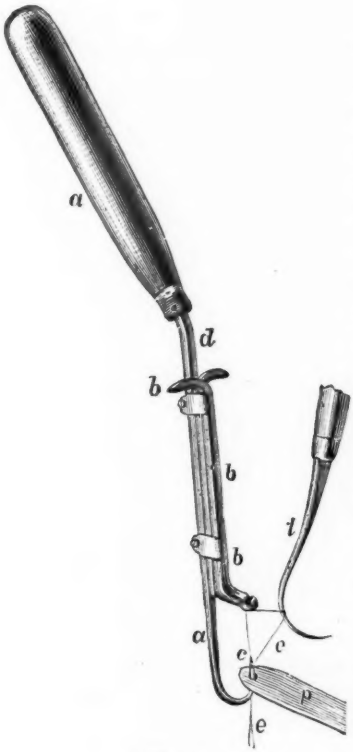


Fig. 11.

*a a.* Shaft and needle-point *c*.

*b b b.* Slide for fixing the needle-point *c* in the tissue to be perforated. Upper *b* the thumb-piece; middle *b* the shaft; lower *b* the foot-piece, with an orifice to receive the needle-point under *c*.

*c.* The needle-point of the shaft *a a*, curved and perforated for the thread *e e*, represented in the cut as passing through a piece of paste-board *p*.

*d.* The thumb-piece of the shaft of a pick-up pin, which seizes the thread and retains it after the slide *b b b* is withdrawn from the needle. The lower end of the thread *e* is behind the paste-board (or in actual use membrane), and the upper end is shown in the cut as having been hooked up by a tenaculum.

*p.* Paste-board to represent the palate or other tissue to be perforated. *t.* Tenaculum for lifting up the thread after it has been drawn up by the slide *b b b*.

The thread is easily picked up by the point of a tenaculum.

It was thought that this device was perfect. My friend, G. V. Black, D. D. S., saw me use this needle, and suggested an improvement by adding a pin, which would automatically pick up the thread. This suggestion was soon realized in the two needles (Figs. 11 and 12); one working from front to rear, and the other from rear to front. The value of these needles can only be appreciated by those who know the difficulty with which those previously constructed are employed.

Fig. 12. Needle and pick-up (receding).

*A A.* Shaft and handle.

*B.* Foot-piece of the shaft, curved. Its extreme point has an orifice, the place of which is indicated by the vertical dotted line. This orifice is perforated by the needle *C* carrying the thread *E E.*

*C.* Needle, with a thumb-piece above and a point below; curved, so that the point will pass through the eye indicated by the vertical dotted line.

*D D.* Pick-up pin, with a thumb-piece above, its sliding shaft intermediate, and its pin-point above the lower *B.* As the shaft (upper *D*) goes down, the pin (lower *D*) moves horizontally and picks up the thread carried by the needle *E.*

*E E.* Thread carried by *C* and picked up by *D*, and retained while the needle *C* is withdrawn, so that, on displacing the shaft *A A*, with its foot-piece *B*, the thread is exposed, and can be seized with a tenaculum.

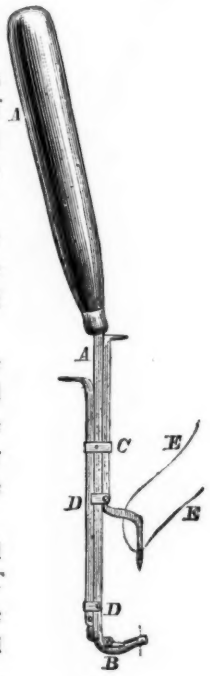

Fig. 12.

The introduction of the sutures is equally facilitated. The point of exit of the needle is invariably determined by the point of entrance, and the stitch never fails to be picked up by the proper management of the instrument.

Silver wire is drawn in by looped thread pilots previously

introduced. The pilots are all first introduced, and then another pilot is introduced, through the galvano-cautery incision, across from one side to the other. These pilots having been all drawn in, the silver wire is drawn in by the pilot, one for each stitch, and twisted one stitch after another, until the stitches are all secured.

While this proceeding is going on, the most convenient instrument for holding the mouth open is Whitehead's gag, represented in Fig. 13.

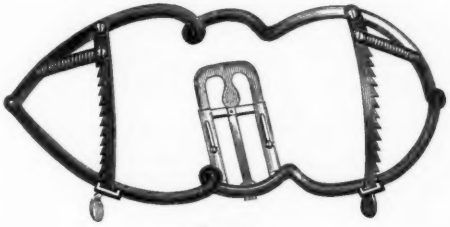

Fig. 13.

Fig. 13. Whitehead's gag or oral speculum, with a tongue depressor, which may be adjusted for greater or less length.

Strong scissors, slightly curved on the flat surface, represented in Fig. 14, are indispensable in the absence of Leslie's nippers.

Fig. 14.

Fig. 14. Strong scissors, curved on the flat surface.

For holding the silver wire while it is being twisted, there is nothing better than Sims's wire-holder, represented in Fig. 15.

Fig. 15.

Fig. 15. Sims's wire-holder, in which the claw is bent at a

right angle with the shaft, instead of being straight or at an obtuse angle, as arranged for the operation for vesico-vaginal fistula.

For twisting the wire, a very convenient forceps is that of Emmet, seen in Fig. 16.

Fig. 16.

Fig. 16. Emmet's twister, held closed by a slide, which can be moved by the thumb of the hand which holds it.

The wire which is to pass through the cautery openings, and is to encircle the central part of the palate, is first armed with an oiled paste-board square, having a small perforation in the center; and as the wire is drawn through, the other end of the wire is armed in the same way. As the wire is drawn down to be twisted, these paste-board squares are made to slide into the fissures occasioned by the cautery, so as to keep the wire from cutting into the tissues. By this means a very considerable degree of compressure upon the inner cauterized surfaces may be secured, without the subsequent ulcerating of the silver wire into the tissues. All possible strain upon the suture line is thus avoided. If union fails it must be from some other cause than the mechanical separation of the surfaces. It is also convenient to place a square under the central part of the wire last mentioned, in order to cover the points of the wires constituting the principal stitches. The tongue is thus protected from contact with their points.

In the preparation of these squares or wafers, thin paste-board is cut into squares, one-third to half an inch in diameter, and perforated in the center. The wire passes through this perforation, and the squares are slipped down at the time of tightening up the wire, so as to bring the paste-board between the wire and the tissue. In order to prevent the early formation of an infectious compound in the paper by the decomposition of the mucus and saliva, the squares are first

soaked in a solution of carbolic acid in castor oil, one in eight. By the time these agents have been dissolved out of the paste-board, the cut surfaces have become proof against the absorption of septic products.

The employment of a spray of ether during this and other operations upon the mouth and fauces, is of no little importance. The patient is first etherized in the ordinary way. The gag is then placed between the jaws, and an assistant commences to blow a spray of ether into the patient's mouth. This he does constantly, except when interrupted by such of the procedures as are inconsistent with it. Care is taken not to blow so continuously upon one spot as to freeze it.

The flow of blood from the surfaces is very much diminished, and much time is saved which would otherwise be consumed in applying the etherized napkin to the patient's mouth.

Dr. Edmund Andrews, of Chicago, has been the first to report this valuable expedient, and he ascribes the suggestion to Dr. Ira Manly, of Markezan, Wisconsin. The surgeon who once employs this expedient will be likely to employ it again.*

Dr. Thomas F. Rumbold, of St. Louis, suggests blowing a stream of cold water through a nebulizer upon parts undergoing dissection, in order to blow away the blood, so that the dissection may go on without interruption at the same time that the constringing effect of cold is produced.

PART II.—URANOPLASTY. Dr. Whitehead's articles, in the American Journal of the Medical Sciences for July and October, 1868, and for July, 1871, afford a full account of Langenbeck's method of closing the cleft of the hard palate. His improvements consisted not so much in doing what had never been done before, as in the recognition of what he was doing, viz., that he was dissecting up the periosteum along with the mucous membrane of the roof of the mouth.

*Chicago Medical Examiner, May 1, 1874.

The knowledge of the possibility and the importance of this proceeding, has led to a method and to a boldness of execution, which have greatly favored both the simplicity and the success of the operation. The incisions are illustrated in Fig. 1, one being made along the inner margin of the teeth, and the other along the margin of the fissure. The strip of membrane, both mucous and periosteal, is then dissected up between the incisions; but the anterior and posterior extremities of the isthmus are left attached, in order to preserve the circulation through the anterior and the posterior palatine canals. That this has been done before will be seen from the followlng quotation from Dr. J. Mason Warren in the American Journal of the Medical Sciences for April, 1848, p. 330:

"When the bones composing the arch of the palate are divided, to dissect off the mucous membrane covering them on each side as far back as the alveolar processes, if necessary stitching it" [the mucous membrane] "across the fissure, and confining it in this situation by sutures; the flaps, it is understood, being made continuous with the fissured halves of the soft palate."

It is impossible to execute this proceeding without taking up the periosteum with the mucous membrane.

There is, however, no recognition by Dr. Warren, of the importance of preserving an anterior attachment, in order to maintain the circulation of the detached membrane.

The proceeding of Warren, and the methods also of Mütter and Mettauer, were crude, from crude conceptions of what should be done and of what they were doing. The sutures employed by Langenbeck are of silk, very probably from the force of habit, and a slowness in recognizing the great superiority of what Sims was the first distinctly to recognize, viz., the quality in a suture which enables it to remain an indefinite length of time in the tissues without irritation or injury; and from being slow to learn that it is easier to twist a silver suture than it is to tie a knot in a thread.

For the details of Langenbeck's method, it is sufficient to

refer to the articles of Dr. Whitehead, already mentioned. The writer has found a convenience in using Warren's knife, (Fig. 17), with which to divide the mucous membrane and subjacent periosteum. Langenbeck recommends making the incision along the teeth, and also that along the fissure, before lifting the periosteum from its bony bed. There may, however, be a convenience in some cases in making first the incision along the teeth, then inserting Sayre's periosteum-lifter, and detaching the periosteum as far as the edge of the fissure, and then cutting the inner edge of the flap loose from the bony edge of the fissure by Warren's knife, passed between the flap and the denuded bone. A wider strip of periosteum can be obtained in this way on account of detaching it from the bone to the very margin of the fissure.

Another variation from Langenbeck's method, after the line of sutures near the margin has been inserted, consists in inserting one or more sutures entirely around the flaps, guarded by squares of paste-board, to distribute the pressure of the stitches, at the same time that the strain is taken off from the line of sutures employed to approximate the margin.

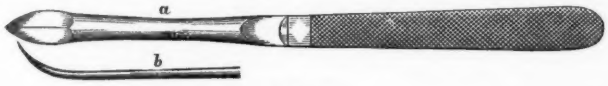


Fig. 17.

Fig. 17. J. Mason Warren's Periosteum Knife. Strong, pointed, and curved upon the flat. *a*, flat view; *b*, edge view.

Fig. 18.

Fig. 18. Sayres's Periosteum Scraper. A convenient instrument for raising the periosteum.

The introduction of thread or wire for conveying and holding the prepared paper compresses is conveniently done with an aneurism needle. This expedient of paper pledgets is adapted to a great many plastic operations, adding greatly to the chances of union by exempting the stitches of the suture line from strain.

When the aid of the outside stitches, with their paper compresses, has become no longer necessary, or at the end of two days, they can be removed, and some days afterward, the stitches of the suture line.

The preparation of these paper compresses has been described in connection with the surgery of the soft palate.

Sir William Fergusson has modified Langenbeck's operation by sliding in some cases, the whole thickness of a section of the hard palate, instead of the periosteum and mucous membrane of the lower surface. The primary incisions are the same, only that the outer incision is nearer to the cleft or farther from the teeth. The bone corresponding with the posterior portion of the outer incision is cut through with a chisel as far back as to the soft palate. This is done on each side; and on bringing the parts together in the median line, an opening is left into each nostril. This opening is expected to close by the development of granulations. The sutures are passed through the lateral incisions, thus completely encircling the central strips.

After describing the proceeding for the employment of the chisel, and the approximation of the parts, Fergusson says of anomalous cases:

"In the generality of severe cleft in the hard roof, the lower and back part of the vomer is incomplete, but in some cases, the vomer is entire, though swayed to one side, and it remains attached by its lower margin to one side of the hard palate throughout.

"Here would be a difficulty which might puzzle; for although the chisel might permit the approximation of the edges, it would be difficult to introduce stitches. But even here there would be a redeeming quality in the new process; for, pushing the parts to the middle line might lay them so together that though union should not occur, they might lie so close, that a fissure might elude ordinary observation."

The obvious suggestion, in this condition, is to peel off the periosteum on the side of the bony arch to which the vomer is attached, while on the other side, the defective palatine

arch is chiseled loose from the alveolar ridge, and brought over to meet the detached mucous membrane and periosteum of the side first mentioned. This method has been practiced by the writer with very satisfactory result.

In this case, the vomer was so bent at its lower edge, as only to be distinguished from the palatine arch by the character of the mucous membrane, the junction of the nasal and the palatine mucous membrane being marked by an abrupt line of color.

A needle in the form of a tenaculum, (the eye being near the point,) to which Black's pick-up attachment is applied, greatly facilitates the introduction of sutures. The tenaculum is placed in the mouth, and the pick-up shaft in the nose, striding the alveolar and labial tissues in front, and picking up the stitch in the dark.

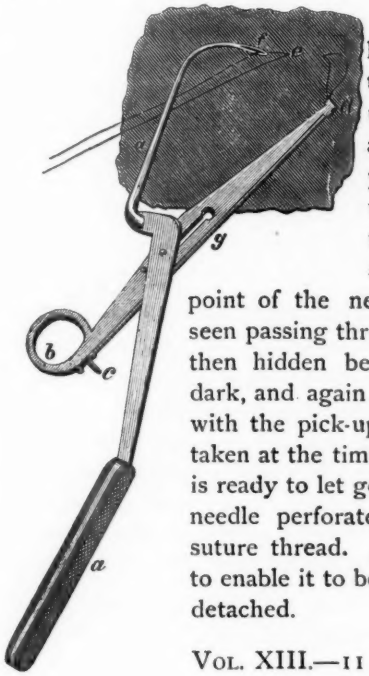


Figure 19. *a a*, shaft and handle of the needle. *b*, the finger end of the pick-up shaft, which terminates at *d*. *c*, thumb-piece of the pick-up stilette, the point of which is in *d*. *d*, the terminal end of the pick-up shaft, which receives the point of the needle. *e*, thread, which is seen passing through the eye of the needle, then hidden beneath the tissue engraved dark, and again emerging to be connected with the pick-up mechanism. The view is taken at the time when the pick-up stillette is ready to let go its hold. *f*, point of the needle perforated for the passage of the suture thread. *g*, slot in the pick-up shaft to enable it to be drawn out of the way and detached.

Fig. 19 is an illustration of this instrument. The needle is made in three forms, with a simple curve like that of a tenaculum, and curved to the right and to the left. The first form is most useful in the operation under consideration; the other two in the surgery of the vagina and rectum.

A convenient length for this instrument, and for all other instruments for the surgery of the mouth, is eight inches, or about twenty centimeters.

Another expedient previously recommended by Dieffenbach, and lately practiced by Fergusson, consists in the introduction of sutures through the bony plate of each side.

This is Dieffenbach's method, copied from Velpeau's Surgery (Townsend's translation, edited by Mott, vol. III, p. 396): "He punches a hole through the edge of the cleft, and inserts a thick, soft silver wire, which is to be drawn and twisted as close as can be, after having first cut down upon and separated the palate bones, where they join the alveolar processes, by means of a thin, smooth concave chisel."

When the division of the three layers (two membranous and one bony) of the hard palate is made, there is evidently greatly increased exemption from gangrene, as the vessels of the palatine vault are very little disturbed.

It is found in the experience of the writer that openings along the alveolar border have a strong tendency to close by the process of granulation, though no such tendency exists in the median line. A knowledge of this tendency makes the operator bold in bringing the two sides of the cleft bony arch together, without fear of the large openings which he leaves alongside of alveolar ridge. The chief caution to be exercised is to provide against too much diminishing the size of the isthmus through which the circulation must be maintained.

*For notices of Fergusson's revival of this method, see Medical News for January and April, 1874; from the Medical Times and Gazette, October 18, 1874; the Lancet for February 28, 1874, and the supplement to the Medical News, July, 1874; from the British Medical Journal, April 4, 1874, and the New York Medical Record, August 1, 1874; from Lancet, June 20, 1874.

JACKSONVILLE, ILL.

# ON CINCHONIDIA.

BY LOUIS S. OPPENHEIMER, M. D.

*House Physician to the Louisville City Hospital.*

I propose to give a brief account of the action of cinchonidia, as observed in thirty-seven cases of disease admitted to Louisville City Hospital in October, 1875. I administered the drug with a view of testing—

First. Its power in lowering animal heat.

Second. Its anti-periodic properties.

Third. Its power, compared to quinia, of producing cinchonism.

## *Action of Cinchonidia on the Temperature.*

Case 1. Age 48; had typho-malarial fever for two weeks; was admitted October 12, 1875, in a semi-comatose condition; temp. 103¼°; pulse, 116. Ordered, cinchonidia 10 grains every four hours, to be given with whisky, 1 ounce.

October 13, 10 o'clock A. M., temp. 101½°; pulse, 108.

At 7 o'clock P. M., temp. 100°.

On 14th, at 9 o'clock A. M., temp. 99¼°; patient more rational and sleeps quietly; began to eat solid food; continued to improve, and was discharged cured on 28th.

Case 2. Came into hospital October 8th, at 6 P. M., in a comatose condition, with remittent fever. It was quite impossible to arouse patient. His temperature was 104½°; pulse, 124, exceedingly weak; was reported to have been comatose twelve hours. Six weeks ago had a tertian intermittent, which lasted two weeks and became quotidian, and for a week past has assumed a remittent form. Ordered, whisky one ounce and carb. ammonia 10 grains, *per enema*, every two hours during the night.

Next morning patient was able to speak and swallow; temp. 102¾°. Ordered, cinchonidia 10 grains every four hours.

At 8 o'clock P. M., temp. 101°. At the expiration of three days, the temperature became normal, and the patient was able to take gentle exercise.

Case 3. Age 24; sick for ten days with typhoid fever; was admitted October 6th; temp. at 3 P. M., 103¾°. Ten grains of cinchonidia were given every two hours. At 7½ o'clock P. M., temp. 100¾°; then ordered drug every four hours.

Three days after, at 4½ o'clock P. M., temp. 103°, when I gave 10 grains, and repeated dose in two hours; temp. at 8 o'clock 102°.

October 10, 9 o'clock A. M.; temp. 101°. The medicine was now discontinued for two days, when the temperature rose to 104⅛, but again came down under the cinchonidia to 100½°. Ten grains were now given thrice daily, and on November 3 temperature was normal.*

Case 4. Age 55; should properly come under the head of intermittent fever, but is reported here in order to illustrate the anti-pyretic, as well as anti-periodic, properties of cinchonidia. Patient was admitted to hospital October 5th; had been suffering for a week with a double quotidian. coming on at 10 A. M. and at 5 P. M.

October 6, at 1 P. M., temp. 98¾°; pulse, 84. Ordered, 10 grains cinchonidia every two hours until thirty grains were taken. No chill occurred at 5 P. M.; temperature, at 7 P. M., 99¾°; pulse 98, and very irregular.

October 7. Gave 10 grains every two hours, from 6 to 10 A. M., and from 1 to 5 P. M., without appreciable effect.

October 8 and 9. Ten grains at 6, 7 and 8 A. M., and at 1, 2 and 3 P. M., without any apparent result, not even producing cinchonism. The pulse was exceedingly irregular and frequent; skin dry and hot.

[Not having Norwood's tincture of verat. virid. at hand, I prescribed the officinal tincture, which is exceedingly varia-

*This patient, being much averse to all kinds of stimulants as well as to milk, was fed for three weeks consecutively on nothing whatever save beef extracts, with the exception of about four ounces of wine daily for the first week.

ble in strength, and directed the nurse to watch the patient closely. I gave it in eight drop doses every four hours. When eight doses had been taken, I was called in great haste to the patient, whose pulse was scarcely perceptible, and but forty-six beats to the minute. He had vomited pretty freely, but was still rolling about on the floor, gasping for breath, speechless, and pointing to his heart as the seat of his agony. I gave him at once some brandy, with aromat. spts. ammon., and in a very short time he regained his speech, and otherwise improved. The pulse remained below fifty for about an hour. The patient had no further malarial trouble, and was soon discharged well.]

Case 5. Age 35; admitted October 9th; had a quotidian fever for twelve days; temperature daily, at 6 P. M., 102° to 103½°. Next day, at 2 P. M., temp. 100¼°. Ordered, ten grains cinchonidia at 2, 4 and 6 P. M.; at 7 P. M., temp. was 98¾°. Patient discharged well a few days after.

Case 6. Age 60; with chronic dysentery; whose daily temperature was 99¼°; took ten grains cinchonidia at 2 and at 4 o'clock P. M., when temperature fell at 6 to 98¾°—less than it had been for two weeks before.

Case 7. Age 52; mitral insufficiency, with an evening temperature of 98¾° to 99°. Ten grains cinchonidia, given at 2 and at 4 P. M., reduced the temperature at 6 P. M. to 98⅛°.

### *Cinchonidia as an Anti-Periodic.*

In the following cases, the last dose was given two hours previous to the time of the expected chill, and the medicine was continued from three to five days, being given in doses of ten grains every two hours till thirty grains were taken. The after treatment consisted of tonics:

### *Cases Cured.*

Case 1. Age 27; tertian; duration before treatment, two weeks.

Case 2. Age 23; quotidian; duration before treatment, two weeks.

Case 3. Age 32; quotidian; duration before treatment, four weeks.

Case 4. Age 35; quotidian; duration before treatment, six weeks.

These four cases were all cured by half a drachm of cinchonidia. The four following cases were not cured with the above doses, but were cured by five grains, administered every half hour, until twenty grains were taken:

Case 5. Age 13; tertian; duration before treatment, two months.

Case 6. Age 27; tertian; duration before treatment, two weeks.

Case 7. Age 35; quotidian; duration before treatment, six weeks.

Case 8. Age 24; quotidian; duration before treatment, three months.

One scruple of cinchonidia was given in the following cases, in doses of ten grains, repeated in one hour:

Case 8. Age 26; tertian; sick five weeks; took twenty grains in the above manner without breaking the succeeding paroxysm; but the next chill was kept off by the treatment, and the patient has now gone two weeks without a chill.

Case 9. Age 28; sick four weeks; quotidian; had tertian intermittent during the first week and quotidian since. The cinchonidia produced purgation, and was discontinued.

Case 10. Age 55; sick eighteen days with quotidian. This case also began as tertian, and continued so for a week. The cinchonidia cured the intermittent, but set up a diarrhea, which ceased only when the medicine was suspended; was again brought on by taking the cinchonidia, and was not arrested for a week. I need hardly remark that quinia has not infrequently produced this same effect, according to my observation.

Case 11. Chronic dysentery and tertian intermittent. The cinchonidia was here given as a tonic, in doses of five grains, three times a day. Patient had taken but four doses when he noticed that his dysentery (which had been somewhat checked for over two weeks), became worse. On stopping the medicine he immediately began to improve in his bowels. On the cinchonidia being repeated, the same result occurred.

*Cases cured with thirty grains, ten grains being given every hour.*

Case 12. Quotidian; sick three weeks.

Case 13. Quotidian; sick twelve days. This case had taken ten grains quinine every four hours for four days, without any effect.

Case 14. Quotidian; sick thirteen days.

Case 15. Quotidian; sick five days.

The following cases were all cured with one scruple of cinchonidia, taken in four doses at intervals of half an hour. In four cases (Nos. 25, 26, 30 and 33), the paroxysm was not completely warded off; but the fever was very slight, and no further attacks occurred after repeating the medicine:

Case 16. Tertian; sick sixteen days; age 21.

Case 17. Tertian; sick two weeks; age 28.

Case 18. Tertian; sick two weeks; age 33.

Case 19. Tertian; sick twelve days; age 64. This man's chill hour was 2 o'clock A. M.

Case 20. Tertian; sick five weeks; age 55.

Case 21. Tertian; sick four weeks; age 41.

Case 22. Tertian; sick 2½ weeks; age 34.

Case 23. Tertian; sick three weeks; age 18. Chill hour was at midnight.

Case 24. Tertian; sick three weeks; age 33.

Case 25. Quotidian; sick seven days; age 21.

Case 26. Quotidian; sick six weeks; age 26.

Case 27. Quotidian; sick twelve days; age 35.

Case 28. Quotidian; sick two weeks; age 29.
Case 29. Quotidian; sick ten days; age 37.
Case 30. Tertian; sick eight days; age 30.
Case 31. Tertian; sick four days; age 32.
Case 32. Tertian; sick ten days; age 33.
Case 33. Tertian; sick six months; age 69.

This man had been relieved several times with quinia, but had not remained well longer than three weeks at any one time; and when he begun the cinchonidia was exceedingly debilitated and generally wretched. He had no more seizures after taking the cinchonidia.

Case 34. Age 30 years; has suffered more or less, with a tertian intermittent, for eight months. Quinia would arrest one, or at most two paroxysms. Cinchonidia first warded them off for fourteen days, and being then given in doses of ten grains twice a day for three weeks, the patient was entirely cured.

To the three following cases, twenty-eight grains of cinchonidia were administered in divided doses—12 grains at 2 o'clock P. M. and sixteen grains at 4 o'clock P. M. During a previous week, the same quantity of quinia was exhibited in the same manner. The action of the alkaloids upon each case was briefly as follows:

Case 1. *Effects of Quinia.*—At 6 P. M., fullness of the head and dizziness, with some feeling of discomfort. In two hours after, considerable fullness of the head, amblyopia, slight exhileration of spirits; then severe headache and marked tinnitus aurium. Effects began wearing off in four or five hours.

*Effects of Cinchonidia.*—At 6 P. M., fullness of the head, and slight amblyopia, accompanied by muscæ volitantes. Two hours later, nothing disagreeable; effects, save a very slight nausea and some dryness of the fauces, subsided.

Case 2. Effects of both medicines the same as those in case 1, except that there was more tinnitus aurium and amblyopia resulting from the cinchonidia than from the quinia;

but this was clearly due to the fact that the patient had been in the habit of taking large doses of quinia.

Case 3. Effects same as those in case 2, though less severe in character, patient being apparently less susceptible to the action of the bark alkaloids than case 2.

Where there is much nausea, quinia is to be preferred to cinchonidia. In several cases of puerperal peritonitis, for example, where the medicines were given by enema, cinchonidia produced less head symptoms than quinia, but increased the tendency to nausea and vomiting; it also had this effect upon other cases where much irritability of the stomach existed.

The cheapness of cinchonidia commends it; and all cases of intermittent and remittent fevers, excepting where contra-indications exist as specified above, are better treated with cinchonidia than with quinia.

In conclusion, I may briefly repeat the analysis of these investigations:

1st. Cinchonidia is equal, and in many cases superior to quinia, as an anti-periodic.

2d. It is equal to quinia as an anti-pyretic.

3d. In persons with very irritable stomachs, it is inferior to quinia.

4th. Its cinchonizing effects, although affecting the head less than quinia, are altogether somewhat more disagreeable.

LOUISVILLE, KY.

## SUCCESSFUL SUPRA-PUBIC LITHOTOMY.

BY GUIDO BELL, M. D.

T. N., a delicate boy, three years and a half old, had, when three years old, a vesicle calculus, the size of a pea, removed; a month after again had symptoms of a stone in the bladder.

On the twenty-fourth of October, 1875, I performed supra-pubic lithotomy, the patient being completely under the influence of chloroform. The stone, which was the size of a large bean, and having abundant crystals on its surface, was removed with the index finger; the incision in the bladder was closed by a single silk suture, silk sutures were used for the abdominal incision, and an ointment, containing carbolic acid and morphine, applied externally to the wound.

In two hours some bloody urine was passed by the urethra, and the patient slept moderately well the first night succeeding the operation. On the twenty-fifth, considerable fever and nervousness; on the twenty-sixth, the superficial sutures were removed, and the wound emitted a decidedly gangrenous odor; and on the twenty-ninth, urine escaped freely through the now opened wound.

On November first, the gaping edges of the wound were brought together with adhesive plaster, and soon after the urine resumed its natural channel. At the end of the month a small fistula existed; but it healed spontaneously by the twenty-fifth of December, and the patient is now quite well.

INDIANAPOLIS.

# Reviews.

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**Le Chloroforme dans les Accouchements Naturels.** Par M. le Professeur PAJOT. Paris, 1875: pp. 29. Chloroform in Natural Labor.

**Leçons de Clinique Obstétricale professées a l'Hopital des Cliniques.** Par J. A. H. DEPAUL, Prof. de Clinique d'Accouchements à la Faculté de Medecine de Paris. Leçon XXXVI. De l'Anesthesie dans l'Accouchement Physiologique. Paris, 1876. Clinical Obstetrical Lectures. By J. A. H. DEPAUL. Lecture XXXVI. On Anæsthesia in Physiological Labor.

Those of our readers who perused the earnest and able article on the safety of chloroform in labor, by Dr. Lunsford P. Yandell, published in the Practitioner for September, 1870, will need no further advocacy of the administration of this remedy in obstetrics, either as to its safety, its beneficial effects, or the justification of its use simply for the suppression of pain. It is not our intention now to write a plea for it. So far as we know, speaking generally, and of those who represent the advanced doctrines of the day in our own country, such a plea is unnecessary. But our purpose is to present the views held by some in other countries; in one country, at least, the capital of which is one of the great medical centers of the world. Possibly the result may be to our readers the same as to us was a visit to some of the places we have been led to look upon as the sources of light. For those who will worship there are shrines this side of Mecca!

The names of the authors who are at the head of our article certainly need no introduction. They have both long been known wherever the science of obstetrics is taught, and both occupy high official position. The work of one is but a pamphlet it is true, originally a journal article, yet a formal expression of the author's opinions on this important subject.

The lectures of the other are the latest emanation of the French medical press; and the work now awaits an introduction to the medical public of our country by some skillful hand.

The question is only in regard to the administration of an anæsthetic during natural labor. In all obstetrical operations, in precisely such conditions as it would be resorted to in general surgery, there is no objection made to chloroform; but in the purely physiological process, simply for the pain-annulling powers of the remedy, both of these writers and teachers reject it entirely.

The first point which strikes the readers of these articles, and one which we think will wonderfully astonish every person who has any practical acquaintance with the subject, is that both these writers deny in the most explicit terms the existence of any such condition as a state of partial anæsthesia! Pain must be abolished entirely, or it still exists; if it exist at all anæsthesia is not, and the woman is only cheated into believing that her sufferings have been diminished! The actual text, alone, we think, could convince our readers that we are fairly stating the position of men of such reputation and standing.

Thus Depaul: "So long as the woman suffers it can not be said that she is really anæsthetised. I insist upon this point because it is evident that the Edinburgh professor and his disciples claim a peculiar kind of anæsthesia. The partisans of chloroform have seen that in the earlier stages of its action, the woman without losing her sensibility and having entire consciousness of what is passing around and in her, does not retain meanwhile the remembrance of her sufferings, so that when this state of semi-lethargy passes away, she either remembers nothing or she retains only impressions so vague that she can be made to believe that she has not suffered. Profiting by this experience, those physicians who are in the habit of giving chloroform in all labors, even the most natural, only induce in their patients the first degree of anæsthesia, to which they have arbitrarily given the name of obstetrical

anæsthesia. * * * * The mode of giving chloroform does not constitute a serious anæsthesia; it is a simple satisfaction given to the woman, who imagines that the affair always passes thus. In England this method has received the name of anæsthesia *a la reine*, because thus it seems Her Majesty's accoucheur treats her in her labors. Can it be said of this method that the patient has been anæsthetised, that is to say, that pain has been abolished? Certainly not. Sacrifice has been made to the exaggerated pusillanimity of the woman, who, often unacquainted with the real pain of labor, imagines she has suffered much less than if chloroform had not been given to her."

Again: "In my opinion there is no such thing as demi-anæsthesia. Of two things only one can exist; either the patients hear the accoucheur, answer him, do what he bids, and in this case they are not anæsthetised and consequently insensible, since sensibility disappears after the intellectual faculties are abolished; or they do not hear, nor respond, nor feel, and in this case alone are they truly anæsthetised."

We will not stop to comment on a practical obstetrician writing of the "exaggerated pusillanimity" of women in labor, but will see what Prof. Pajot says. He uses very nearly the same words, and he not only denies but he ridicules:

"If she is not conscious of her condition, if she does not hear, nor understand, nor obey, if when pains come she does not feel them and does not complain, sure enough anæsthesia is real; but who will dare to say that it is not dangerous? And the accoucheur is alone!"

"If the woman sees, hears, understands, speaks, obeys, cries out, the situation certainly is not dangerous; but is this *anæsthesia*, is it *demi-anæsthesia*, is it *quarter-anæsthesia*? We answer it is not anæsthesia at all, or it is anæsthesia of the thirtieth dilution which is the same thing."

"We are to ask the woman, then, 'Have you roaring in your ears?' 'No, sir.' 'Then you are not demi-insensible.' 'And now?' 'Yes, sir.' 'Good; then there you are in the

state of demi-insensibility.' Which calls up the famous dialogue: 'Are you deaf and dumb?' 'Yes, sir.' 'Very well.'"

These extracts are explicit enough. We are not to believe what almost daily takes place under our eyes, and is part and parcel of our daily professional experience, as testified to by the warmest expressions of gratitude. But it would be useless to say anything to these writers of the gaateful expressions of patients. Such expressions "prove absolutely nothing. If we terminated every labor by the unnecessary application of the forceps we should be overwhelmned with expressions of gratitude and joy for the very fault of which we had been guilty." [Pajot.] No, these leading obstetricians of the French capital go so far as to reject entirely the testimony of the patient herself as to the value of the remedy. It certainly will not be believed upon mere statement, therefore we present the proof.

Depaul, continuing our former quotation, after detailing the usual mode of giving chloroform in labor, says: "The professional chloroformists, in doing this, *simulate an anæsthesia which they do not produce, and address themselves more to the imagination of the woman than to her physical sensibility.*"

Thus Pajot:* "In a word, the *pretended demi-anæsthesia rests upon nothing else than an equivocation.* The women and the families believe, upon the word of the physician, that the beneficent method which permits an amputation without suffering, is going to be applied to labor. The patient continues to complain and to cry out until the end. She is given to understand that things always go on thus; she believes it, more or less. Let the women believe, if they will, that they are delivered under chloroform, incapable as they are, in their ignorance, of knowing whether the practice of *demi-anæsthesia*, this appearance, has anything in common with chloroformic anæsthesia, this reality.

"The proposal to employ chloroform in natural labors has the chance for a long time of being accepted by women and

* In this and the following quotations, the italics are in the original.

their friends, who confound, thanks to equivocation and ignorance, anæsthesia *a la reine* with *true anæsthesia.* The irresistible mirage of '*sans douleur*' does not disappear even before the reality. The women are given to understand that they would have suffered much more without the semi-anæsthesia. Chloroform is, for the accouchees, like Providence, always to be thanked when one has broken a leg; it might have been both!"

Nothing can be plainer than this. The woman says her sufferings are relieved, begs vehemently for more, at the end pours out grateful thanks for relief of agony. But it is all a mistake; she was deceived; there was no relief at all! In other words, the case is in court, and the only witness in the case that really knows most of the affair—the only one who knows all about it—is coolly ruled off the stand! With such proceedings any cause may be gained or lost.

It is not for us, perhaps, to attempt to explain this. The history of medicine has, unfortunately, like the history of every other branch of human knowledge, chapters which would bear transcribing bodily into the great projected work of Bulwer's Caxtons—"The History of Human Error." We fear this is one of these. How few, even of the most elevated, are entirely free from prejudice and partizanship.

We have said nothing of the *tone* of these writings. They are both, of course, hostile to chloroform so far as its use in natural labor is concerned; but while Depaul is dignified and the more just, Pajot is far from either, with his very frequent allusions to "the pretended demi-anæsthesia," and his "exposure of one of the errors of Simpson, a spirit more brilliant than judicious." This arises undoubtedly more from the polemical character of his pamphlet. It is evidently a reply to an advocate of chloroform in natural labor—an advocate neither temperate nor judicious, to judge from the extracts he gives. Who it is we do not know, as no names are given.

But neither of these gentlemen is clear as to the facts. Thus both treat, as an accepted doctrine, of chloroform being limited, by those who administer it in natural labor, to the

concluding period of the expulsive stage, just while the head is clearing the vulvar outlet. We know of no such limitation in practice, or by recent writers of authority in our language. If we were called upon to give a model instance in which chloroform in natural labor did the most good, not only in relieving pain but in shortening the process, we would select as a type, a primipara, in whom full dilatation of the os had not yet taken place, the expulsive power early active, driving the head down to effect dilatation by mechanical force as much as in any way. The first stage of labor is not yet completed; the anæsthetic is given to relieve the pain of the passage of the head through the uterine outlet, and well it does its work. The agony is so great that the woman holds back every possible influence which favors progress; under chloroform she brings to bear all her voluntary powers, and this "*pretended demi-anæsthesia*" shortens the process as much as it relieves suffering.

In Depaul's work alone do we find any statements or arguments demanding serious consideration. We transcribe his conclusions:

"I reject chloroform absolutely in simple normal labors: 1. Because the use of anæsthetics, although the contrary has been said, is not without danger and may kill the patient. 2. Because the anæsthetic sleep, in depriving her of consciousness, does not permit, in the great function which she accomplishes, a participation which is almost always necessary. 3. Finally, because the danger and the inconvenience are not compensated by the advantage which results from the diminution or the suppression of pain."

To commence with the second proposition. The author having denied the possibility of a demi-anæsthesia, a condition in which the woman's sufferings are mitigated and yet sufficient consciousness remains for her to aid the process of labor by voluntary effort if necessary—the question is not open for debate. We simply affirm in reply, and are satisfied with the results we see daily under our hands, and do not imagine that this experience is either rare or singular.

But in regard to the first proposition, the question of danger, it is a far more serious affair; and as he enters into the subject at some length, we looked for considerable new light upon this, one of the most important points in obstetric medicine.

As to *argument*, he makes one good point. He is considering the claim, made by the advocates of chloroform, that women in labor show a special immunity to danger from it.

"I will say only that most frequently the cases of death from chloroform have been observed at the beginning of the anæsthetic inhalation, and not at an advanced period; that is to say, at a time when there might be a saturation with the remedy."

The deaths from chloroform at an early period of the administration have always been a mystery, and have proved the stumbling-block of many theories. We have our own explanation of them, which we will not repeat here, because we have a more pertinent question to ask, and that is, "Have deaths thus occurred to women in labor?" Because if they have not, the argument, drawn from their occurrence in cases of general surgery, fails utterly.

This, then, brings us to his *facts*.

"As to the claim that there is not in a single relation of a case of death by anæsthesia to a woman in labor, I am far from being convinced that this absence of official publication is a proof that this accident has never been observed in these cases. The men who habitually practice this mode are too much interested in the question to hasten to make it known. For my part, I know of at least two cases of death in Paris; but it is so easy to attribute them to other causes."

A grave insinuation, and an indefinite statement of two deaths! Is this all? No; two cases more. They may be found, and M. Depaul felicitates himself upon finding them just in the nick of time for his lecture, in the American Journal of Obstetrics, for August, 1874, page 278. They are two cases related by Prof. Lusk to the New York Obstetric Society. In one case death took place twenty-four

hours after the chloroform was administered! In the other, dangerous symptoms occurred, and well they might, for the administrator "held the handkerchief tightly over the patient's face, thus excluding the air!"

This, then, is all! Two deaths indefinitely alluded to. If these two deaths really occurred, M. Depaul owes it to science—owes it to himself, to the position he occupies—to give them in detail. Without this being done no argument can be based on them. But, admitting them, and then again we say, *this is all!* This is all that outspoken opponents of the administration of chloroform in natural labor can give in now about thirty years' experience with the remedy! This is satisfactory. We challenge the production of any other remedy possessing any considerable fraction of the power, for which as much can be said.

We have presented here the views and doctrines of two men of position in the French capital as to the administration of chloroform in natural labor. They have their followers, their adherents, and exercise their influence; we can therefore judge of the extent to which the practice is followed there. Convinced in the strongest degree of the benefits and harmlessness of the practice, we can only reply, in a travesty upon the opening line of the Sentimental Journey, "they [do not] order this matter better in France."

J. C. R.

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**A System of Midwifery, including the Diseases of Pregnancy and the Puerperal State.** By WILLIAM LEISHMAN, M. D., Regius Professor in the University of Glasgow, etc. Second American, from the second and revised English edition. With additions by JOHN S. PARRY, M. D., Obstetrician to the Philadelphia Hospital, etc. Philadelphia: Henry C. Lea.

The first edition of Leishman's Midwifery was so fully noticed in a former number of this journal, and it has been so cordially received by the profession, that it is not necessary to enter into a detailed examination of this second issue.

One of the most important additions—both alteration and addition—occurs in connection with the subject of puerperal fever. Dr. Leishman, in common with most of those at home and abroad who have given special study to the subject, is ready to reject "specific puerperal fever" from the catalogue of diseases.

But the most valuable additions to the volume are those made by the American editor. One of the best tests of a man's ability is for him to take a standard work in our profession, like this of Dr. Leishman, and materially improve it. Many a one, with more ambition than wisdom, has attempted it with other books and failed. But Dr. Parry has succeeded most admirably. We know no obstetrical work that has anything better, *on the use of the forceps*, than that which Dr. Parry has given in this, and no work that has the rational and intelligent views upon *lactation* with which he has enriched this.

Having used "Leishman" for two years, as a text-book for students we can cordially commend it, and are quite satisfied to continue such use now.

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**Transactions of the Illinois State Medical Society, 1875.**

A volume of reports and voluntary papers of a highly creditable nature. One of the latter exhibits the astonishing fact of two hundred and fifty cases of scarlatina cured with "iodide of potash." When will men having the degree of doctor, which means *learned*, cease to commit this chemical solecism? The epidemic, perhaps, was not very malignant.

Drs. Hamilton and Earle favor the quinia treatment of hooping cough, in a long report.

Dr. Prince affords a characteristically philosophical dissertation on galvano-therapeutics; Dr. Freer on transfusion of blood; Dr. Curtis on pathological anatomy of serous tissues;

Dr. Massie on insanity; Dr. Rood on obstetrics, particularly the latter; in fact all the reports are well written, and present important material.

The society is evidently, as all societies ought to be which love their work, pregnant with ambitious enthusiasm.

J. G. R.

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**The Body and its Ailments.** A Hand-Book of Familiar Directions for Cure and Medical Aid in the more usual Complaints of Adults and Children, etc., etc. By GEORGE H. NAPHEYS, A. M., M. D. Philadelphia: H. C. Watts & Co.

This book is designed by its industrious and well known author to do good; and he certainly has embodied in small space very much useful information. In the hands of some, Napheys' Body and its Ailments will be invaluable; but in the hands of others, it will give that little knowledge which is no where so dangerous a thing as in medicine, and lead to a vast amount of meddlesome, mischievous drug-giving.

Why, indeed, should there be doctors at all, if, in these encyclopedic pages, every one can be familiar with that usual complaint, Addison's disease, and learn its treatment, and that extraordinary one, warts; can learn how to diagnose and treat that plain and simple malady, pericardial dropsy, that difficult one, flea-bites, that frequently occurring disease, tetanus, and those grave and rare complaints arising from lice and the itch insect! The book attempts too much—its chief failure arises from this.

Nor can we always approve its therapeutics. We do not believe that the profession of this day, for example, will indorse the mercurial and acetate of lead treatment of dysentery. A part of the treatment advised in pneumonia is, in our opinion, equally questionable.

# Clinic of the Month.

DILATATION OF THE FEMALE URETHRA—ITS MEANS AND ITS USES.—The St. Louis Medical and Surgical Journal, February, publishes the following abstract of a recent lecture by Professor G. Simon, of Heidelberg:

In order to remove calculi and other foreign bodies from the bladder, resort has been had to various operations—bloodless dilatation and section of the urethra, vesico-vaginal and vestibular section, and the high operation.

Of these methods, only two are recommended for the facility with which they permit not only foreign bodies to be removed, but diseases to be diagnosticated and treated.

Dilatation may be accomplished gradually, or at once, in a few minutes. The rapid mode is preferable, because the long retention of a bougie is apt to produce inflammation and swelling of the urethra.

The observation that the urethra admitted of dilatation was very early made. Wildt, who describes my procedure, in the "*Archiv für Klinische Chirurgie*," gives many citations. I will refer in addition to Franco (*Traité des Hernies*, 1861,) Fabricius Hildanus, Peter Dionys, and Bertrandi. Sir A. Cooper five times removed calculi through dilated urethræ. Hybord (1872) describes the process of dilatation, and declares the introduction of an instrument greater than 3 or 4 centimeters in circumference impossible. Christopher Heath's plan was to first introduce his little finger, afterwards his index finger, giving it a rotary motion.

Notwithstanding these observations, dilatation did not become popular, because of the limited indications, and fear of the resulting incontinence. My method, developed through

a long series of experiments, has, I believe, dispelled these objections.

The orifice is the narrowest and most unyielding part of the urethra, and it is seldom that the finger can be introduced without using great force. I generally make two incisions in the upper margin of the orifice 1.4 centimeter deep, and one below 1.2 centimeter deep. The finger being thicker at its base, unless these incisions are made, will lack at least 1 centimeter of penetrating its entire length. The incisions are best made with a pair of scissors. No harm can come of this slight operation. Few muscular fibres are divided, the little muscles heal, and in the future they obviate the use of chloroform.

For dilating I use seven sizes of hard rubber bougies, the largest being 2 centimeters in diameter, the smallest ¾ centimeter. After using these, I introduce my index finger without difficulty, taking care, at the same time, to introduce my middle finger into the vagina; for, in this way the bladder may be more deeply penetrated, the urethro-vesical septum pressing the commissure of the finger. I also press, with my other hand, upon the base of the bladder.

The fear of incontinence has interfered to such an extent with bloodless dilatation, that Hybord (1872,) after careful research, only found twelve cases where the operation had been performed for the extraction of stone. Knowing this, I set to work to discover how far dilatation might safely be carried. Hybord and Spiegelberg are the only authors who have given definite estimates. No practical benefit can be derived from their statements, because they differ so widely. Hybord says it is unsafe to dilate beyond 3–4 centimeters in circumference, 1—1.3 diameter; Spiegelberg says 2.5 centimeters diameter, =7.8 centimeters circumference, and even beyond this. The bounds prescribed by Hybord are absurd, for even a child's finger is 3 or 4 centimeters in circumference. My numerous observations have taught me that bougies 1.9--2 centimeters diameter=6—6.3 centimeters circumference, may be used without any disaster worthy of mention. Slight ruptures of the

mucous membrane may result, but these heal in a few days. Authors who have mentioned the removal of calculi have invariably neglected to state whether incontinence resulted or not. I have arrived at the conclusion that in girls from 11 to 15 years old the urethra may be dilated 4.7—5.6 centimeters circumference,=1.5—1.8 centimeters diameter; from 15 to 20 years, from 5.6—6.3=1.8—2 centimeters diameter, and that in only exceptional cases. The objects to be attained by dilatation are:

1. The diagnosis of diseases of the mucous membrane of the bladder by palpation. Illumination of the interior of the bladder with the calcium light becomes of practical importance, for the finger having determined the site of the disease, the light can be intelligently directed.

2. Very small stones may be felt and removed. Heath sought in vain with instruments for a stone, which he easily found and removed with his finger.

3. Formerly calculi were sought to be grasped without the guidance of the finger. Now the instrument may be introduced along with the finger. Lithotripsy will be more available, and the dangerous operation of urethrotomy will fall into disuse.

4. Caustic applications may be made in obstinate cases of chronic vesical catarrh.

5. For the cure of fissures of the urethra. Heath adopted with good results, the plan of dilatation with cauterization. Spiegelberg pursued the same course. I can not say that I have been uniformly successful.

6. The diagnosis of vesico-vaginal fistula in closed vagina. Wildt mentions a case in which, by palpation, I pronounced a vesico-vaginal fistula curable, opened up the artificially closed vagina, and cured the fistula by bringing its margins together. I have since treated a second case of the kind with good results.

7. The diagnosis of the location and extent of tumors, and swellings between the bladder and vagina. In the numerous cases of carcinoma of the uterus in which the vesico-

vaginal septum is implicated, it is important to know whether the mucous membrane of the bladder is involved, for, unless this is intact, the tumor can not be removed without opening the bladder.

8. The extirpation of tumors, especially of papillomata in the walls of the bladder.

9. Renal calculi which happen to be arrested near the orifices of the ureters may be diagnosticated and removed, either by incising the orifice of the ureter, or by making an incision through the mucous membrane of the bladder.

10. The opening of a hematometra, whose evacuation between the bladder and rectum is impossible or too dangerous, on account of the congenital absence of the whole or a part of the vagina. In such cases, Scanzoni evacuates the collected menstrual blood through the rectum. The peritoneum is invariably wounded by long incisions, and openings by trocars close, and relapse occurs. If opened through the bladder, the peritoneum is unharmed. Nöggerath's trocar is very useful for the purpose.

11. The cure of the painful and otherwise ultimately fatal vesico-intestinal fistula of large and small intestines. A fistula is easily found by the finger, passed through the dilated urethra, and caustic applications made, guided by the finger or endoscopic illumination.

A more Effectual Method of Applying Iodine to the Interior of certain Cysts.—Mr. Furneaux Jordan, Lancet, January 29, remarks as follows upon this topic:

"I have found that there are in practice two classes of scrotal hydroceles, in which the ordinary methods of treatment are either difficult to use or uncertain in their result. In boys and men there are occasional encysted hydroceles of the testis, or the cord, which continue to increase in size, or in which treatment is urgently requested. In such cases, except in early infancy, acupuncture, or the use of a fine trocar, often fails to cure. The walls of the cysts are usually thin, and collapse so much when their contents are withdrawn that the

injection of a fluid is uncertain. The end of the canula may be outside the cyst, and the iodine solution be consequently injected into the connective tissue at its exterior. In such cases the following is a reliable method of treatment: The cyst being well isolated, made tense, and brought near the surface, I pass through its center a stout needle, armed with silk, and leave the threads hanging. The fluid quickly oozes away, especially if a little traction be made on the threads. I then, at one opening, wet the threads with iodine liniment, (liniment, because the quantity required is so limited,) and draw the threads so as to leave the moistened portions within the cyst. A little gentle friction will help to spread the iodine thoroughly over the lining membrane of the cavity. An hour later, freshly moistened portions may again be drawn through if the cyst be large, or if other methods of treatment have failed. On the other hand, in a very small cyst, a single thread, moistened and kept in one hour, will suffice.

"Another class of cases are those of simple vaginal hydrocele, in which the injection of iodine and other ordinary methods of treatment are unsuccessful. An interesting case will best convey what I wish to say. A young man had a moderate-sized hydrocele. Trocar puncture and acupuncture repeated a few times failed, and consequently iodine tincture (undiluted) was injected. In a few weeks the collection had reached its old size. A silver-wire seton was then put in; whilst in, the cyst remained empty, but its removal was followed by reappearance of the fluid. I then, at three o'clock, passed through the cavity a double silk thread at two spots. In a few minutes, when all the fluid had oozed out, I drew the threads, moistened with iodine liniment, into the serous cavity. I directed him to repeat the process in an hour. He was so anxious to get well—he was shortly to be married—that he moistened the threads four times in six hours. At midnight the effects had become so sharp that he was glad to remove the threads as he had been directed. He remained at home one day only, and was shortly and permanently well. I venture to believe that no kind of hydrocele will resist

this method of applying iodine, and consequently that the setting up of suppuration, even as a last resort, can rarely be necessary."

HEMATOMETRA — SPONTANEOUS RUPTURE — RECOVERY.— Prof. Valentine, Memorabil., January 21, 1876, reports two cases of hematometra, in each of which rupture occurred and recovery:

The first case occurred in a woman four months after parturition, and the obstruction arose from inflammation following. The uterus reached as high as the umbilicus, and was extremely sensitive. The patient would not submit to puncture of the uterus, and nothing was done but using morphia hypodermically. Finally a spontaneous opening into the vagina occurred, and the patient recovered.

The second case occurred in a girl of seventeen, who had never menstruated, and who was being sent on the cars to the hospital to be confined! An abundant discharge of dark blood suddenly took place, and before she reached her journey's end the only symptom of a suspected pregnancy, the abdominal enlargement, had disappeared. An examination showed a recent rupture in a hitherto imperforate hymen.

ERGOT FOR THE INTESTINAL HEMORRHAGE OF TYPHUS.— Dr. Plagge, *ibid*, strongly recommends the extract of ergot, in combination with tincture of opium, with cherry laurel water as a vehicle, and given every half hour, in the treatment of hemorrhage from the bowels occurring in typhus fever. He has found the ergot much better than ice and astringents.

SALICYLIC ACID FOR OFFENSIVENESS OF BREATH AND EXPECTORATION.—Dr. Da Costa, Medical and Surgical Reporter, prescribes salicylic acid, five grains, dissolved by means of a drachm of glycerine in half an ounce of water, taken three times a day, in cases where the breath or expectoration are offensive. If internal administration does not accomplish the desired result, it can be used with the atomizer in a solution of similar strength.

# Notes and Queries.

OLD NOVELTIES.—In the ebb and flow of medical theories and practice, we frequently have the same views and rules presented at different times, claiming attention on account of their honestly alleged novelty, just as one standing by the sea shore beholds an object borne upon the advancing wave, which, in fact, the receding one had merely carried out of sight.

These opinions and phases of practice meet one every now and then, especially in our periodical literature; they may be uttered by new voices, they may wear new garbs, but in spite of disguises one is tempted to think, even if he should not say, It seems to me I have seen you before. The recognition of old acquaintances in new dress, in medicine, is certainly not useless, and just now we propose devoting a little time to a few such acquaintances that have recently been made the objects of some professional attention. These old novelties are not all so very advanced in years as to be quite venerable, but still less are they so young that they are entitled to wear the swaddling clothes of infancy, and awaken all the interest and sympathy which babies of recent birth and of great promise may claim. Questions of parentage, of course, are involved in this consideration; and if these parental relations can not always be plainly established, at least we can do the next best thing, show where they are not.

Dilatation of the female urethra, as to method and as to its diagnostic and therapeutic purposes, is elsewhere, in this number of the American Practitioner, admirably presented in the abstract of a recent lecture by Professor Simon.

Two questions of priority, not to say originality, are suggested in this connection. Who first proposed the treatment? Who resorted first to immediate dilatation?

Mr. T. Prigdin Teale, in the initial paper of a series, *On the Treatment of Vesical Irritability and Incontinence of Urine in the Female by Dilatation of the Neck of the Bladder*, Lancet, November 27, 1875, p. 766, observes, "I have failed hitherto to find any authors who have proposed this, or any similar treatment, for affections of the female bladder."

In Dolbeau's *Leçons de Clinique Chirurgicale*, delivered in 1866, published in 1867, Mr. Teale will find cases similar to those which he has given, and urethral dilatation urged as the essential treatment. These lectures were published at least two years before he instituted a similar practice; for he states that his first case "occurred about eight years ago."

Again: In the American Journal of Obstetrics, November, 1875, Dr. Henry T. Bahnsen, of Salem, N. C., is credited with priority in forcible dilatation of the female urethra, the operation having been done by him three times from 1869 to 1872. The editor refers in this connection to operations in 1872, one by Dr. Gale, of Louisville, Ky., the other by Dr. Edwards, of Richmond, Va., where the dilatation was rapidly effected by the finger. An earlier example of such use of the finger will be found in Sir Astley Cooper's *Complete Surgical Works*, p. 443; and in the very volume of Dolbeau to which reference has been made, *la dilatation forcée* is directed; and this is at least three years prior to Dr. Bahnsen's operations.

For our next illustration, we must turn to an excellent article in the American Journal of the Medical Sciences, January, 1876, by Professor Ellerslie Wallace, of Jefferson Medical College, and entitled *A New Mechanical Treatment of Irreducible Flexions of the Uterus*. This new mechanical treatment is by sponge-tents. But is it new? Some physicians, who never had the pleasure of hearing Dr. Wallace's excellent instructions, have been pursuing this treatment for some time, and, like Moliére's character, who had been talking prose all his life without knowing it, never thought of our obligations to this eminent teacher.

In the second edition of Courty's *Maladies de l'Uterus*, the

author advises, as an important part of the treatment of anteflexion, the use of the sea tangle tent, and remarks that the tent causes *redressement* of the body upon the neck. So, too, Sir James Simpson, *Diseases of Women*, New York, 1872, in his lecture upon *retroversion of the uterus*—and he includes, under this head, retroflexions as well, regarding them as arising under the same conditions, producing the same symptoms, and amenable to the same remedial measures—observes, p. 780: "My excellent friend, Dr. Moir, has made an ingenious suggestion for the treatment of obstinate retroversion, which is more especially useful when the displacement is complicated with hypertrophy, and which I have several times employed with good results. You introduce a sponge or tangle tent into the cavity of the uterus, which becomes at once straightened and expanded, and the organ thus rectified is more likely, on contracting, to retain its proper situation."

Bearing in mind what has already been stated in regard to the views of Sir James as to posterior version and flexion, it will be easily understood that the utility of the tent was in the latter rather than in the former. And, indeed, upon referring to Dr. Moir's article, Edinburgh Medical Journal, vol. 5, July, 1859, to June, 1860, p. 700, we find its title, *On Retroflexion of the Unimpregnated Uterus, with Cases illustrative of its Causes, and of a New Mode of Treatment.* Dr. Moir's first case of retroflexion, successfully treated with a sponge tent, was in 1857. Edinburgh cured only retroflexion; Philadelphia all flexions; Edinburgh followed the tents by a short use of a sort of stem-pessary; but Philadelphia succeeded without it; the Athens of the North had a New Mode of Treatment in 1859, while the Centennial City had to wait for A New Mechanical Treatment until 1876. One is tempted to ask, how old a treatment must be before it ceases to be new?*

And now for a third and last example of an old novelty.

* In the course of his paper, Dr. Wallace attributes to Dr. Sims first indicating the value of sponge tents in removing hypertrophy. If the reader will turn to p. 65 of Sims's *Uterine Surgery*, he will find the credit for this observation given Dr. Emmet by Dr. Sims.

For this we pass from Philadelphia to New York—from staid and venerable Jefferson to busy, wide-awake Bellevue.

The January number of the New York Medical Journal contains an article entitled, *On the Treatment of Amputations by the Open Method.* In this article it is stated that "for over a year nearly all the amputations in Bellevue Hospital, in the third surgical division, have been treated by the open method;" that "to Dr. James R. Wood is due all the credit for introducing and carrying into effect this great reform in surgery, which has given such wonderful results on the other side of the water;" and that he has "revived a method of treating stumps, which was unwisely rejected."

Upon turning to the *Transactions of the American Medical Association*, 1875, pp. 244–5, it will be found that Dr. J. E. Link, of Indiana, presented to the *Section of Surgery and Anatomy* a paper entitled *A New Method of Amputation*, in which he advocated "healing the stump as an open wound." This method of treatment did not begin in Dr. Link's hands only a year ago, but in 1863; and both in military and civil practice he has had a much larger number of amputations thus treated than the number where a similar practice has been pursued at Bellevue. It is Dr. Link's intention to present the subject fully, so far as his experience goes, at the next meeting of the American Medical Association, and to vindicate what he believes his just claim to priority, in this country, in the open treatment of stumps.

He has now had not less than one hundred and ninety amputations, one hundred and fifty in military and forty in civil practice, treated by the open method; and as he entered his *caveat* last June, and his operations commenced thirteen years since, it is rather too late for a new claimant, whose operations date back only a year, to come forward in January, 1876.

And now, concluding these old novelties, Philadelphia was thoughtless to ignore the previous labors of Edinburgh, and New York ungracious to claim for Dr. James R. Wood a glory which we believe is justly due Dr. John E. Link, of Terre Haute.

THE ANNOYANCES OF A REVIEWER.—When an author or publisher sends a pamphlet or book to a medical journal, the editor has a duty to his readers, and is not to think of pleasing the author by indiscriminating and undeserved praise, or helping the publisher to dispose of his wares.

The Practitioner has endeavored to be independent and intelligent in its reviews and book notices, and to act for the good of its readers; its errors have oftener been of kindness than of severity of criticism.

Dr. Walter Coles is the author of a monograph upon "Abortion," which was reviewed in the January number of our journal. This review we believe was just, giving the author quite all the credit his production deserved, and pointing out some obvious faults. Instead of trying to profit by well-meant criticism, Dr. Coles sends the following weary and vain communication, requesting its publication as a matter of "fairness and courtesy."

We publish it—though its fairness and courtesy are nothing to speak of—merely suggesting that the review to which it is supposed to be a reply should be read in connection with it, and remarking that a writer who finds the etymology of the word pill an excuse for discrediting the definition of medical dictionaries and common use, ought to know what focus means and how it should be used, from its etymology, as well as appreciate at once the absurdity of "engrafting seeds."

3004 OLIVE ST., ST. LOUIS, Feb. 9, 1876.

*To the Editor of the American Practitioner:*

DEAR SIR: My attention has been called to a review of my recent paper on "Abortion," etc., contained in the January number of your journal, in which the writer has been pleased to compliment our "extensive research," etc. These words of commendation are, however, mingled with criticisms which savor so much of snarling carpishness as to require some notice at my hands. I am the more prompted to this course for the reasons that the criticisms in question (having no initials appended) seem to have been inserted with editorial

sanction, and that they involve at least one matter of practical importance.

The reviewer complains that he experienced much difficulty, owing to the vagueness of my expressions, in getting at the "*ideas*" set forth in this pamphlet, and proceeds to hold up to ridicule certain words and phrases shocking to the senses of a well educated physician. When, for example, I recommend one grain of extract of belladonna and two grains of extract of opium, "to be made into a pill" and passed up to the os uteri, in cotton saturated with glycerine, on going to bed, he is horrified that I should call anything "*a pill*" which is "*not to be swallowed!*" But he explains this blunder in a foot-note by saying: "Dr. Coles elsewhere speaks of *engrafting seeds* and of a *focus of hemorrhage*." Now, since my critic is curious to know why I called a thing not intended to be *swallowed a pill*, I will endeavor to enlighten him. I am all the more willing to do this, since it is a point of practical moment, for it is barely possible that some one, after reading this review, might be silly enough to call it *something else*, and write a prescription ordering these ingredients made into a *suppository*, in which case the druggist would almost certainly add enough cacao batter to enable him to mold the mass as usual, thus giving the patient a different and very much less efficient medicament than the one intended.

This might suffice as a practical answer to my reviewer, but since he confesses to an obtuseness in catching my "*ideas*," I will venture to still further augment his stock by suggesting that the word "*pill*," from its derivation, means literally a "*little ball*," and this irrespective of its uses. The ancients even applied the term to particles of *sheep dung*—but we are not informed that it was on that account something intended to be "*swallowed*."

The criticism of the expressions "*engrafting seeds*," in the phrase "manage to engraft upon themselves the seeds of ill health," and of "*focus of hemorrhage*," in the sentence "it is frequently impossible to remove the after-birth without leaving more or less behind as the focus of fresh hemorrhage,

irritation and poison," needs no notice at our hands while there are so many unabridged dictionaries in the land.

In conclusion, my amiable and generous friend is referred to an article by Richard Grant White, Esq., in last November's number of the Galaxy, on "*Heterophemy*." Perhaps he may there see himself as others see him.

Very respectfully, WALTER COLES, M. D.

ICONOCLASM.—We heartily commend to any of our readers who may have erected in their souls an altar to the unknown god or goddess, *vis medicatrix naturæ*, a perusal of the following extract from an address delivered by Dr. J. Matthews Duncan before the Edinburgh Obstetrical Society:

"I have already said that the difficulties in the way of subjecting all departments of medicine to scientific method are very great. For the history of the subject, and some natural prejudices, make it almost painful to reject the old philosophical treatment of it. We appear to many to be almost, if not altogether, impious, if, in the spirit of modern science, we decline to admit the existence of the vital principle, or any such power or force, under whatever hallowed name it may be identified, for whose existence there is no scientific evidence, and against the probability of whose existence there is very much. Yet we must decline to take refuge in any such asylum of ignorance, and do our best to make it a hornet's nest for any philosopher disposed to flee to it. In like manner we appear rude if we reject the *vis medicatrix naturæ*, which should be the deity of expectants. To trust in such an imagined force, such a helpmate for the spurious philosophers, would be ridiculous in a scientific man. He would be resting on a *vox et præterea nihil*. To say that a wound is healed by the *vis medicatrix*, or any disorder righted by the same, would be equivalent to, and even more ridiculous than saying that the watch was repaired by the watchmaker's fee. All such difficulties as are involved in the giving up these fine phrases, which have long kept the profession employed in beating the air, must be cheerfully met. We must learn to believe in an ignorance more honorable than pretended and

false science, and to say with humility and boldness we do not know; and the acknowledgment of ignorance will be the first step toward replacing the ghost of a name by the substance of real knowledge."

Congenital Deformities.—Dr. Whitted, of Ellettsville, Ind., communicates the following case of malformation:

"Mrs. B., aged thirty, gave birth, February 6, 1876, to a healthy male child, which had the following defects: Hare lip and cleft palate; the index and middle finger absent on both hands, the corresponding metacarpal bones present; the second and third toes of each foot were absent, with presence of corresponding metatarsal bones. The great toe of the right foot was much larger than the great toe of the left, and to the feel gave the impression of a union of two toes, though, from external appearance, it looked like a natural toe. The fourth and fifth toes were natural in their conformation, though they were firmly united together. The parents of this child were healthy, though the mother had congenital hare lip, which had been cured by operation.

"Having noticed, in the Practitioner for January, a statement of a case almost similar to this, which was thought to have been produced by maternal impression, I thought it might be of interest to state that in this case no alleged cause was mentioned by the parents. I learned from a neighbor, however, that about the time the mother became pregnant she became very much frightened over her child, which had attacks of spasms."

An Apology.—The Nashville Journal of Medicine and Surgery, for February, which was not received until the 26th of the month, contains an article upon *Cinchonidia*, which is essentially the same as the one published among the original communications of the American Practitioner. It was then too late to withdraw it from our journal, and we can only give this apology to our cotemporary, hoping that Dr. Oppenheimer, the author of the article in question, can give some reasonable explanation of the fact of his contributing the same paper to two journals.

VIRCHOW.—In the Boston Medical and Surgical Journal, February 17, there will be found, in the conclusion of an interesting letter from Berlin, the following sketch of Virchow:

"All in all, he is one of the most remarkable medical men I ever knew. His *personnel* is by no means striking. He is below the average German stature, of a dingy complexion, and with an impassioned expression; one fails to detect the depth of his researches in science, or the strong will, or the cutting sarcasm which characterize him. An hour in the Pathologisches Institut easily demonstrates his accurate study in that part of medical science to which he has devoted the most hours of the best part of his eventful life. His political tenets, at variance with those of the chancellor of the empire, and in sympathy with that large radical party of Germany whose ideal may be seen in every European government of to-day—call it by whatever name you please, liberalism, radicalism, or conservatism—have developed an iron will and a bitter sarcasm which make him a species of terror to the government. In other ways he is remarkable. Always late at his lecture, and appearing now but twice a week, he has time enough, apparently, for the numerous demands made upon him. On the same day he is to be seen, from 9 to 11 A. M., in the Pathologisches Institut, demonstrating, with a vast array of material, cellular pathology; and from 5 to 7 or 8 P. M. in the Chamber of Deputies of Prussia, of which, this week, he was elected Vice President, over the nomination of his predecessor; later, at work in the Royal Geographical Society. Besides these official appointments, he is chief editor of a pópular journal of science, contributes occasionally an article to scientific bodies, and gives popular lectures in the winter. I have alluded to his life as an eventful one. It may not be generally known on our side of the water that, in the revolution of 1848, he fought as a common soldier behind the trenches; that he was forced to abandon his professorship here on account of his political doctrines, and that he went to Würzburg, where the book of his life—the exposition of the cellular pathology—was written; that the government was obliged to recall him to his department in the university

on account of the urgent demand of scientific men, who recognized his worth by the new book; that later, Prince Bismarck challenged him to a duel, whose acceptance he had the courage to refuse; these, and many other events of his life, make Rudolph Virchow one of the most conspicuous men of the day in Germany. I am told that he regrets the comment not long ago made about him, that he was a severe critic as to the merits of other men. Virchow is poor, lives on the second floor, and complains that he can not live as a gentleman of his standing should."

JEALOUSIES AND BICKERINGS IN THE PROFESSION.—The following is an extract from a communication with the above suggestive title, found in the February number of the Atlanta Medical and Surgical Journal, written by Dr. J. M. Johnson; it is well worth reading and reflection by every physician:

"There are men who can not look upon a rival, or admit a superior; who know and feel their inferiority, but who struggle to keep the world from knowing it, and to this end they whisper and wink and attempt, by malice in the dark, to make things even. The man who wastes his life in pleasure-hunting and prodigality, turns communist, and demands that his neighbor, who has been laborious and thrifty, shall divide with him. Such has been human nature from the beginning, and such it will be at the ending. But reforms are needed. It is utopian to think of making men equal by education. The professional beggar will thank you for a nickle, while the college-bred beggar demands a suit of clothes and money enough to take him to the centennial. By cheapening education you sometimes develop men into something who would otherwise be nothing, but generally you burden society with men who live and die drones, because they have been forced from their true base. Cheap medical education is a great factor in the evils we are deprecating."

THE LOUISVILLE MEDICAL NEWS.—This new and meritorious candidate for professional favor is issued weekly by J. P. Morton & Co. It is conducted with signal ability, which, indeed, any one would at once believe who knows its talented and scholarly editors, Drs. Cowling and Galt.